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S. HRG. 101-490

RURAL HEALTH CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON
MEDICARE AND LONG-TERM CARE

OF THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

MAY 19, 1989

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RURAL HEALTH CARE

FRIDAY, MAY 19, 1989

U.S. SENATE,
SUBCOMMITTEE ON MEDICARE AND LONG TERM CARE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:00 a.m., in Room SD-215, Dirksen Senate Office Building, Hon. John D. Rockefeller, IV [chairman] presiding.

Also present: Senators Pryor, Daschle, Heinz and Durenberger.

[The press release announcing the hearing follows:]

[Press Release No. H-24, May 5, 1989]

FINANCE SUBCOMMITTEE TO HOLD HEARING ON RURAL HEALTH CARE

WASHINGTON, D.C.—Senator John D. Rockefeller IV, (D., West Virginia), Chairman of the Senate Finance Subcommittee on Medicare and Long Term Care, announced today that the Subcommittee will hold a hearing to explore how possible reforms of Medicare policies could ease the health care crisis in rural America.

The hearing is scheduled for *Friday, May 19, 1989 at 10:00 a.m.* in Room SD-215 of the Dirksen Senate Office Building.

Chairman Rockefeller said, "The problem is complex, there is no one solution to make sure rural Medicare beneficiaries have access to quality health care. This hearing will be an opportunity to explore a variety of approaches to modify or change Medicare policies to improve the health care system in rural America."

Rockefeller said, "Health care in rural America has always had troubled times, but now the crisis is truly unfolding. Shortages of health care workers are becoming more severe and, as a result, the health of many rural Americans is worsening. Rural residents are more likely to suffer from chronic disease conditions, including arthritis, visual and hearing impairments, heart disease, hypertension, and emphysema."

"In many isolated, rural areas of our country," Rockefeller said, "it is the sheer determination and strong will of a few dedicated individuals that are keeping the doors of many health care providers open."

"Because a disproportionate number of elderly live in rural areas, it is critical we examine ways that the Medicare program can improve access to health care services in rural communities," Rockefeller said.

OPENING STATEMENT OF HON. JOHN D. ROCKEFELLER, IV, A U.S. SENATOR FROM WEST VIRGINIA

The CHAIRMAN. Good morning. I am delighted that everyone, including myself, is here.

A couple of weeks ago, Lloyd Bentsen, the Chairman of our Committee, held a hearing on rural hospitals. There was enormous interest in exploring ways to try to help rural hospitals, not necessarily an easy task. Rural areas have slightly more Medicare beneficiaries than urban ones, therefore rural hospitals are disproportionately dependent on Medicare. Rural hospitals are described as the cornerstones of health care in the rural community. Rural hospitals give stability to rural communities and are the economic foundation for many of them.

But it is the health care professionals—the doctors, the nurses, the physicians' assistants, and the psychologists and others—working in the hospital, at the clinic, or out in the field that are the real centerpieces, in fact, of rural health care. But we have some very serious problems.

The Department of Health and Human Services identified 1,292 rural primary care shortage areas last March. That is a lot of areas for shortage areas. As many as 25 percent of rural physicians may retire or leave their communities within the next 5 years.

In fact, when I talk about doctors in this setting, I rhapsodize on rural physicians and there is always one particular person, that I know very well, who comes to mind and that person is not yet fifty. The mass of paperwork, the hassle, the pressure of having to be so many things to so many people—to take care of the high school football team, to be the County coroner, to be on call 24 hours a day. Anything that happens in that rural community he has to do. I talked to him recently and he is thinking of getting out of the profession.

The number of nurse practitioners practicing in rural areas has declined and has declined, in fact, from 22 percent in 1977 to only 9 percent in 1980. The percent of physicians' assistants located in communities of less than 10,000 has dropped from 27 percent in 1981 to 19 percent in 1984.

I have introduced a bill this year that would provide for Medicare reimbursement for psychologists. Psychiatrists do not practice in at least 60 percent of West Virginia's counties. Almost 20 percent of West Virginia senior citizens live in counties that have psychologists, but no psychiatrists.

I feel my bill is a necessary step. I think it is an appropriate step. It is not the only step, but I think it helps in terms of rural health care and in terms of access to mental health care under Medicare.

I also plan, in fact, to introduce a rural health clinic bill that breathes new life, at least as I see it, into an existing program—and that is the Rural Health Clinic Act. Congress enacted the Rural Health Clinic Program to increase the availability of primary care services to residents of rural areas. When the Rural Health Clinic Act was first introduced in 1977, it was predicted, at that time, that there would be 2,000 rural health clinics that would spring up across this nation by next year —1990.

That has not exactly been the case. In fact, as of today, there are only 450 rural health clinics nationwide. Something went wrong. In West Virginia we have 32; and I am very pleased with that. Minnesota, I am told, has only three rural health clinics. I am surprised at that. Montana and North Dakota have no rural health clinics. There is a startling lack of awareness of this program, I have found, in many parts of this country. So my bill begins to address some of those problems.

We are intensely interested in your ideas as to how to make a true system of rural health care work; and, obviously, that is why we are here.

I would call on the ranking Republican member of this committee, who is superb in health matters, and from whom I learn on a daily basis.

OPENING STATEMENT OF HON. DAVID DURENBERGER, A U.S. SENATOR FROM MINNESOTA

Senator DURENBERGER. Mr. Chairman, thank you very much for the compliment; and thank you for your introductory comments.

I am very pleased that we are having this hearing as a follow-up to the full Committee hearing. I think you and I, and our colleague from Arkansas, Dave Pryor, were both struck at that time by the fact that all but one of the members of the Committee showed up for most of that hearing. I guess that means that to some degree that the fact that the Senate is different from the House has a lot of meaning to public policy in this country.

We represent constituencies that are a microcosm of the Nation as a whole. The message is finally getting through that there are two Americas. It is very clear and it is not just the Appalachia of your State, Mr. Chairman, it is all of rural America today, which in the era of deregulation and deflation and decentralization and everything, all of rural America is adversely affected by the law of large numbers when we come to deal with efficiencies in the delivery system.

We are penalized for our conservatism. We are penalized for the way we did cross-subsidies—in other words, asking the providers to carry most of the load for the folks that could not afford health care. Now the present system penalizes us for that and we are in desperate need of changing that system.

But I would say, Mr. Chairman, that was you and I learn at home, and our colleague from Arkansas, Dave Pryor, learn at home, we will learn today. And that is that we must look at rural health care in the larger context of rural America and the fact that there are fewer resources available, and that the present economic systems are driving people from the places where they used to learn values and things like that into places where they live on top of each other and lose their values very quickly. And if, as a Nation, those values are important to us, then as a matter of fact, the subject matter that we are addressing is critical.

Doing something about the hospital payment system this year is critical. Doing something about reimbursement for physicians this year is critical. Doing something about facilitating the outreach into rural America—your clinics and some other things—is critical. I mean, it is past the stage of smiling and saying, well, we have to do the deficit first. We are losing. We are losing in rural America; and we are losing very quickly.

I think this hearing and your commitment to this cause is very critical.

Thank you.

The CHAIRMAN. Thank you, Senator Durenberger.

Senator Pryor.

OPENING STATEMENT OF HON. DAVID PRYOR, A U.S. SENATOR FROM ARKANSAS

Senator PRYOR. Mr. Chairman, I have a statement that I would like to be placed in the record at the appropriate point and I will just ask you as Chairman to do that.

But I would just like to make a comment in response to Senator Durenberger and, Mr. Chairman, in response to your opening statement. I want to first congratulate you for holding this particular hearing, not only for the announcement of the introduction of your bill which was introduced last night.

I can remember, it seems to me like yesterday, but several years ago when Senator Russell Long was the Chairman of the Committee on Finance. I remember he gave sort of a dissertation one morning on from time to time how we in this system of government might take the Tax Code that we have, and through the tax code implement social policy. Now a lot of people may think that we should not use the Tax Code to implement social policy, but I think that we have reached a point, Mr. Chairman, and my colleague from Minnesota, Senator Durenberger, where we ought to relook at using the Tax Code to reach into a deep void and vacuum where we have got to do something about rural health care.

I introduced yesterday, Mr. Chairman, a bill which I hope will compliment your bill. I hope it will expand upon your bill. It is very simple. It does use the Tax Code. It grants a $12,000 a year tax credit, with a five year service incentive for those physicians who practice in medically underserved parts of rural America. We use that as a tax incentive for these physicians to locate a practice there.

The second phase of my legislation, Mr. Chairman, is using the Tax Code for the elimination of a current tax disincentive for rural physicians and RNs and other personnel to locate in rural America. This would eliminate the taxation of those funds given to health care providers through the National Health Service Corps Loan Repayment Program. Today, these funds are taxed. Partly as a result of this being a tax, we see only 26 physicians today in the United States of America who have availed themselves of this particular program. This is a tax disincentive I think that we can look at eliminating.

I think it will help a great deal in making a forward step in eliminating the maldistribution of physicians in the United States.

With that said, Mr. Chairman, I once again have a statement I would like placed in the record. I compliment you again for holding the hearing. I think this could be a major first step that we are taking in these pieces of legislation to directly, through legislation, improve the quality of rural health care.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much, Senator Pryor.

Mr. Jeffrey Human is the Director of the Office of Rural Health Policy, HHS, sitting right in front of me and we welcome your testimony.

STATEMENT OF JEFFREY HUMAN, DIRECTOR, OFFICE OF RURAL HEALTH POLICY, DEPARTMENT OF HEALTH AND HUMAN SERVICES, WASHINGTON, DC

Mr. HUMAN. Thank you very much, Mr. Chairman, and members of the Subcommittee. I appreciate the opportunity to review with you this morning the progress of the Office of Rural Health Policy. Let me also congratulate you on holding this important hearing and on assembling the distinguished panelists who will present testimony this morning.

In August of 1987 the Secretary of our Department of Health and Human Services created an Office of Rural Health within the Health Resources and Services Administration. This office was the predecessor to the current Office of Rural Health Policy. Thus, it is a little less than 2 years old. I was named the Director of the Office at the time of its initiation.

The creation of the office was a response by the Secretary to the same kinds of concern that have been expressed by the three of you this morning—about access to health care in rural areas, particularly about the problem of the viability of small rural hospitals. It should also be noted that a number of Senators and Congressmen urged the Secretary to create such an office. Among the Senators who wrote the Secretary to support the creation of the office were eight of the twelve members of this Subcommittee, including the three of you who are present this morning.

The office became the Office of Rural Health Policy in December 1987 as a result of the passage of the Omnibus Reconciliation Act of that year that made the new office a permanent part of the Department.

The major responsibility of the office is to work within the Department and with other Federal agencies, States, national associations, foundations, and private sector organizations to seek solutions to health care problems in rural communities. In particular, the office:

Advises the Secretary on the effects that the Medicare and Medicaid programs have on access to health care in rural communities, especially with regard to the viability of small rural hospitals and the recruitment and retention of health professionals in rural areas. The office also assists in the development of Department regulations and policies responsive to the resolution of these issues.

We coordinate rural health research within the Department and administer a grant program which supports the activities of Rural Health Research Centers.

We provide staff support to the National Advisory Committee on Rural Health.

Perhaps most importantly, we articulate the views of rural constituencies within the Federal establishment.

We are a small office. Currently we are staffed with seven professionals, including one detailed from the Health Care Financing Administration. We expect a second detailee from HCFA, as it is called, in the near future. This office brings together staff with a great deal of expertise in rural health issues.

We have a number of completed projects and several pending that we count as accomplishments, some with other organizations.

For example, we staff the National Advisory Committee on Rural Health. The purpose of this Committee is to advise the Secretary on priorities and strategies that should be considered for addressing the issues and problems related to providing and financing health care services in rural areas. This 18-member Committee is chaired by Robert D. Ray of Iowa and includes members from both the private and public sectors who have a broad range of experience and expertise in rural health.

I have attached a list of Committee members in my testimony statement. The Advisory Committee has just finished its third meeting last Wednesday.

Another important role of the office is public representation. We have shared information on rural health problems through presentations, conference calls, articles and professional papers. Our emphasis has been on the various proposals for State and community action as well as Federal action to solve some of the problems that we face. We have come knowledgeable about these programs and believe that this informal information clearinghouse role has been perhaps our most important role.

The office plays an important role in the Department with respect to rural health research. The Rural Health Research Center grant program was included as a part of the 1987 Omnibus Reconciliation Act. Within ten months of enactment, in September of 1988, we had made grants to the Universities of Washington, Arizona, North Dakota and North Carolina, and the Marshfield Medical Foundation in Marshfield, Wisconsin.

These centers collect and analyze information, conduct applied research on rural health issues and disseminate the results. The project directors of the five centers meet twice each year with us to collaborate and share information and set priorities. They will meet with us, actually, at the beginning of next week for their second meeting. The first monographs from the center, the University of Washington, have been disseminated describing the rural hospital and its role in the community.

We have provided the assistance that enabled the National Rural Health Association to increase publication of its Journal of Rural Health from two issues per year to four issues, thus doubling the amount of research this respected Journal can publish each year.

Also in conjunction with the National Rural Health Association we will be issuing a compendium of recent and ongoing major research projects in rural health during the summer of 1989.

In concert with the Assistant Secretary for Planning and Evaluation, we will publish during the summer a paper describing six case studies of innovative rural health delivery programs. Programs that have succeeded where many others have failed.

One of the initial mandates in the office was involvement in Medicare activities. We have developed a strong working relationship with the Health Care Financing Administration, around its legislative and regulatory proposals and its policy development and research proposals. As a part of this relationship, we have provided recommendations on numerous issues to HCFA, ranging from support for a Montana demonstration that has been approved to provide support to failing rural hospitals and enable them to convert into community health facilities with short-term bed capacities, (called "Medical Assistance Facilities"), to recommendations to support for higher annual payment updates for rural hospitals. The latter recommendation, incidentally, has been accepted this year by the Secretary, only last week.

We are currently assisting HCFA in the design and implementation of a program of grants to rural hospitals to make transitions in their roles in the communities they serve. That program also was authorized as a part of the 1987 Omnibus Reconciliation Act, with the active sponsoring of Senator Durenberger.

We will publish a Primer on Medicare Hospital and Physician Payment during the summer of 1989. This primer will be designed for lay readers, such as trustees of rural hospitals, to gain a basic understanding of the complex policies and procedures that Medicare uses to reimburse hospitals and physicians for the services they render to Medicare beneficiaries.

Our largest individual project is a telecommunications project that we manage. It is a departmental demonstration that is establishing an interaction satellite-based video communications system and data exchange between teaching hospitals and rural physicians and rural hospitals in West Texas. Texas Tech University is the grantee.

Interagency coordination is important to our office. We have established ongoing collaborative efforts with the Department of Transportation on emergency medical systems and the Department of Agriculture on rural economic development.

I hope you have noted prior to this hearing that we have been very active in legislative liaison. We provide assistance to congressional staffs on a variety of technical issues and on local problems. I have testified at field hearings of the Senate Appropriations and Senate Aging Committees; the House Appropriations Subcommittee on Labor, Health and Human Services; and state groups, such as the Texas Legislative Task Force on Rural Health, as well as to this Subcommittee.

We are establishing an information clearing house next year. We are well into the design phase of the project and if the President's budget is approved, it calls for the funding necessary to begin that Center next year.

In summary, Mr. Chairman, although we are a relatively new office and we are a small office, we believe we have been able to help resolve rural health problems through serving as a voice of the rural health constituency within the Executive Branch, through the programs and research we have initiated and through the technical and general assistance we have provided in rural America. We hope to continue to be of assistance in these matters.

This concludes a slightly shortened summary of my formal statement, Mr. Chairman. I will be happy to answer any questions you may have.

[The prepared statement of Mr. Human appears in the appendix.]

The **CHAIRMAN**. Thank you very much, Mr. Human.

Senator Daschle, we welcome you, sir.

Senator **DASCHLE**. Thank you, Mr. Chairman.

The CHAIRMAN. We will give you a moment to catch your coffee, and then if you have a statement to make or some wisdom to impart, we will want to hear that.

It is odd to me—what you are meant to be doing is giving technical advice and promotion and a variety of things of that sort. Montana does not have any rural health clinics. It has none. We called up to find out why and they said they have never heard of this act. They had never heard of it. Now Texas does not have any, but there is a different reason for that. So, you know, one has to look at it carefully.

But if they have never heard of it, that says, at least, the specific part of the legislation which talks about promoting the concept of rural health clinics, et cetera, has not gotten through. So I am wondering what it is that you are doing about that.

Technical assistance, promotion, a variety of other services that have not reached the Montanans. Two thousand was meant to be the target by 1990; 492 is the fact, so there has got to be a reason for that and I am interested in what you think those reasons might be.

Mr. HUMAN. Well, I think there are several reasons and I think one of them is the lack of publicity and information about the rural health clinic program, as you indicate. We have been working with the Health Care Financing Administration to try to correct that problem. For example, when the program was first started in 1977 a descriptive brochure was developed and was shared widely to explain the program and the application process. That fell into disuse and now HCFA is having it redone.

The CHAIRMAN. Am I right in thinking that there really has been no promotion of the rural health clinic program by HCFA since 1979?

Mr. HUMAN. I would not say there has been no promotion done, but there has been very little done since that period of time, until recently.

HCFA now has designated persons in all of the ten regional offices who are going to be the contact points on the Rural Health Clinic Act, as well as three persons within the HCFA central office to whom calls can now be directed. The brochure will help to direct callers to those people when it is published in the near future.

The CHAIRMAN. Who does the brochure go to?

Mr. HUMAN. That will go to the States, to the current clinics, to the hospital and medical associations, to a wide variety of health providers across the country.

The CHAIRMAN. What does it make available to them so to speak? What does it tell them?

Mr. HUMAN. It describes the program, and the advantages of the program, and the process for applying. I have not seen the final because the Health Care Financing Administration is right now working on the development of it. But that is what the original brochure did and that is what I think this one will do as well.

The CHAIRMAN. Why did they start doing something about it recently and what happened in the interim ten years?

Mr. HUMAN. Well, that brings some of the other problems that we have had with the program. For a number of years, the maximum payment rate was fixed at $32 and interest in the clinic program as a result of that began to wain during that period of time. But when the Congress raised that level to more than $46 last year and more than $47 this year, then it became a very viable alternative for maintaining stability in private medical practices across the country. At that stage republicizing it became much more important than it had been in the past.

I would mention that there were at least some other problems, and are some other problems, that you have alluded to with respect to this program. Restrictive State practice acts in some States, for example.

The CHAIRMAN. Describe those for me.

Mr. HUMAN. Practices that provide, for example, that physicians' assistants may not be licensed in a given State or that nurse practitioners are required to practice in the immediate office of a physician who provides supervision, rather than being allowed to practice at a remote site with more occasional supervision. Those kinds of problems have occurred. Also there are some shortages of nurse practitioners and physician assistants across the country in the same way that there are shortages of other health personnel. And then, of course, the reimbursement level was too low until recently.

We are in the stage now, I think, where we are correcting a lot of those problems and providing publicity.

The CHAIRMAN. Senator Grassley has introduced a bill which essentially makes the promotion part of all of this much more visible by placing it in the Office of the Assistant Secretary of Health in HHS. Do you have a reaction to that?

Mr. HUMAN. The Department has not taken a position on that bill yet. I would say that with respect to the specific placement of a function in a particular office of the Department of Health and Human Services, I would expect the Department would probably oppose that, since in general the Secretary likes to reserve that kind of management decision to himself.

The CHAIRMAN. Senator Daschle is here and I think South Dakota does have a number of rural health clinics; North Dakota has none, in terms of rural health clinics; Montana has none. West Virginia is very odd, in fact, in that it has so many. I am obviously very happy about it, but not entirely sure of the reason why. Maybe it is just because it is closer to Washington and we hear more about it. But clearly, hearing about it and knowing about it is crucial, and ten years seems like a long time to wait.

I am not trying to badger you.

Mr. HUMAN. Oh, no. I think your comments are very well put. The only thing I would say in defense is that I do not believe that the leading officials of the Health Care Financing Administration, or other officials of the Department, were fully aware until several months ago of how important this Act was to rural constituencies. I believe we were able to play a role in bringing that to the attention of the Department. I believe that the Health Care Financing Administration is now working diligently to try to provide this information to states and to the private sector as well about the program.

The CHAIRMAN. Senator Daschle, do you have a statement? You are not at this point on the priority top list for questions, but you are right at the top of the list for statements.

Senator DASCHLE. Mr. Chairman, I have no statement at this time. I appreciate having been given the opportunity, but I will forego my statement.

The CHAIRMAN. SENATOR HEINZ.

Senator HEINZ. Mr. Chairman, I do have a statement but would ask that it be entered into the record in its entirety. I would recommend to you that if there are a large number of rural health clinics in West Virginia, my advice would be to ask members— [Laughter.]

Mr. HUMAN. Senator Heinz, I believe my data shows that there are a large number in Pennsylvania as well.

Senator HEINZ. I have never been Governor in Pennsylvania. [Laughter.]

Senator HEINZ. Which is certainly less than Senator Rockefeller can say in the case of West Virginia.

[The prepared statement of Senator Heinz appears in the appendix.]

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. I don't know, sitting between a Heinz and a Rockefeller, I don't know what to say. [Laughter.]

Except we only have three rural health clinics in Minnesota. I wanted to be a Governor once, but I gave it up. [Laughter.]

The two issues I guess I would like to ask you about, Jeff, the first relates to your principal reason for your being here is to advise the Secretary on the affects that the Medicare and Medicaid programs have on access to health care in rural communities, especially the viability of hospitals and the recruitment and retention of health professionals.

If you had to explain, in thirty seconds or a minute, and that is all you had to give to the Secretary, what would your advice right now as to what the condition is in rural America and what we have to do about it?

Mr. HUMAN. The biggest problem is access to health care. The biggest two parts of that are access to rural hospitals, which have been failing during this decade and the other part is shortages of health care personnel, to take care of people in those areas.

Senator DURENBERGER. And what is your recommendation about what to do with it?

Mr. HUMAN. We are not going to solve these problems unless we work together as a Federal government, as States, as local communities, and in terms of the private sector. I think that there are a lot of things that we need to do. Like the Congress, we in the Department have been looking over the last few years, at the payment levels for rural hospitals. I think that raising those levels is having its effect. I think we also have to look at programs like the National Health Service Corps that provide physicians to rural areas and what we can better do to assure the effectiveness of that program.

But similarly, we have to look within States to the kinds of programs that they have in affect that are important—such as the medical and nurse education training programs.

Senator DURENBERGER. Are we in agreement that if we just rely on the third party reimbursement systems—existing third party reimbursements systems—in this country to save all rural hospitals, that it cannot be done?

Mr. HUMAN. It cannot be done. That represents just a little bit more than a third of all of the revenues of rural hospitals. We also have to look at other important issues, such as declining admissions in rural hospitals—why that is happening and whether that is going to stabilize. We have to look to uncompensated care. As the rural poverty rate has been rising, uncompensated care has been rising as well. That represents not only personal tragedies for the people who are having difficulty seeking care, but it means that rural hospitals have greater difficulty maintaining their services.

Senator DURENBERGER. Now if we were going to start and set an order of priorities here in terms of the things that we could get our hands around in terms of time, would we be in agreement that maybe the first thing that we could do is to make sure that, as a government, those third party payment systems over which we have some control are at least paying something approximating the traditional costs plus a fair return on investment? I am talking principally about Medicaid, mental assistance, Medicare, the Indian Health Service, some of these other public health services, some of these other programs. That the first commitment we ought to make is at least we ought to carry our load for our third party payers. Is that correct?

Mr. HUMAN. Yes. In answering that, what I would like to do is take just a moment and convey to you some of the recommendations that have been passed in the National Advisory Committee on rural health in that regard.

Senator DURENBERGER. And their first specific charge was to deal with the issue and the problem related to providing and financing health care services in rural areas?

Mr. HUMAN. Exactly.

Senator DURENBERGER. All right.

Mr. HUMAN. So their recommendations may be relevant to you. These are recommendations, incidentally, that have not yet been conveyed to the Secretary, but they were made in public session.

Senator DURENBERGER. And this is this Wednesday's, meeting?

Mr. HUMAN. That is correct. They have recommended, with respect to the point you just made, a Medicare payment floor for rural hospitals with less than 50 beds and for sole community hospitals. The floor would be the hospitals' actual costs. Over the longer term, I believe that Committee does not believe that we should support all hospitals in that fashion. But they believe that in the short term, in order to stabilize the situation, that that kind of a solution is necessary.

Once we have been able to define which hospitals are essential to access in rural areas, then the Committee would recommend that we limit paying full costs to those hospitals.

Senator DURENBERGER. Are you talking about costs or are you talking about charges? What are we——

Mr. HUMAN. The payment floor would be for costs, I believe. Costs.

Senator DURENBERGER. What currently are you doing? Are you paying them 100 percent in capital?

Mr. HUMAN. Correct.

Senator DURENBERGER. So 100 percent across the board. That is for 50 beds or less?

Mr. HUMAN. Correct.

Senator DURENBERGER. Then you have some provisions for sole community providers, expanding that definition?

Mr. HUMAN. Yes, that is correct.

Senator DURENBERGER. Did they address regional——

Mr. HUMAN. And incidentally, you know that the Secretary has proposed in the update regulation, only last week, that the definition of sole community hospitals be revised so that the distance between hospitals be dropped from 50 miles to 35 miles.

Senator DURENBERGER. Is there any recommendation regarding the regional referral centers and changing the definitions?

Mr. HUMAN. No, not at this point. But you must remember that the Committee is a committee of volunteers, all of whom have other jobs, that has been meeting three times. The first meeting was organizational. The Committee hopes to address rural referral centers as well as other issues as they go further along.

Senator DURENBERGER. This is going to be my last question. Have you looked at the issue of the way in which the smaller SMSA hospitals and the regional referral center hospitals, with their higher reimbursements, but similar costs are, in effect, draining business away from similar hospitals located in rural areas without regional referral status, without SMSA status and how much money we are losing in this system?

Mr. HUMAN. I understand the point that you are making. But, no, we have not been able to do a detailed analysis on that.

The CHAIRMAN. That is an interesting point, Senator. In other words the rural health centers in West Virginia, or clinics, are very dynamic. They tend to be staffed by young, rather aggressive people—nurse practitioners and physicians' assistants. Part of the bill that I am introducing helps straighten out some of the problems that can keep them there. There are some technical problems. But they are very attractive and they might, in fact, be a threat to the occupancy rates of hospitals or visits to rural hospitals.

Senator DURENBERGER. Well, that is a follow on potential and I think the critical point that we are all experiencing, and I wish I could have thought of a West Virginia example to illustrate it, but we know—and you know from your experience in West Virginia and I will just speak to mine in Minnesota—that the same hospital located in a rural community and in a nearby SMSA, doing the very same thing, the very costs and so forth, have a rather wide reimbursement differential.

Now that differential enables the SMSA or small urban hospital to make money. That money they make enables them to come out into the rural areas and compete, in effect, for patients and take patients away from these small rural hospitals; and that effect on top of the lower reimbursement in your maybe 100 bed, 75 bed, but located in a rural area hospital, that too is further complicating this. As a matter of equity it is taking money out of the trust fund, that we do not need to take out. Because if you can buy the same service for $100 why pay $125 for it. Which is a point we have been trying to research with this demonstration on the Lake Region Hospital in Minnesota.

But I know you experience this in West Virginia; and Tom I know you experience it; and Dave you do too.

Mr. HUMAN. Senator, I should note that one of the other recommendations of the Committee is that the Secretary recommend establishment of a single national standardized payment amount by fiscal year 1992. In other words, the urban rural differential would be phased out over 3 years. That would be an important step in minimizing the differences in total reimbursement between urban hospitals and nearby rural hospitals.

Senator DURENBERGER. I am glad we gave you time to say that and I hope we move the date up.

Thank you.

The CHAIRMAN. Senator Pryor.

Senator PRYOR. Thank you, Mr. Chairman.

Mr. Human, is anyone looking—is the National Advisory Committee, for example, looking at the Medicare reimbursement to physicians, say, for office visits?

Mr. HUMAN. Yes, sir.

Senator PRYOR. Now did you cover that in your opening statement?

Mr. HUMAN. No, I did not. The National Advisory Committee is doing that. One of their first recommendations is that the Secretary recommend legislation to Congress to increase the floor for rural physician reimbursement under Medicare from 50 percent of prevailing charges to 80 percent of prevailing charges, to be effective October 1, 1989. This is an interim recommendation based on the assumption that the longer term solution of implementing the resource base relative value system will not be possible this year. But once that happens, that is probably a better way to approach that problem.

Senator PRYOR. Now I had a physician the other day in my office from a rural community in southern Arkansas. In fact, it is a wonderful name for a town—Smackover—Smackover, Arkansas, in the lower part of Union County. This physician told me that he was reimbursed, I believe it is $13 for an office visit. Now his first cousin, who practices either in New York or Connecticut, I am not certain, is reimbursed for the same office visit, the same amount of time, I believe it is $32.

Now is this something that you are looking at?

Mr. HUMAN. Yes, if the Committee recommendation were accepted to increase the floor, that would result in higher payments to the physician in Smackover.

Senator PRYOR. What is that doctor down there in Smackover—What is he going to get? How much then—Is he going to move closer to that $32 that his cousin is getting or is cousin going to move closer to the $13? [Laughter.]

Mr. HUMAN. That is a good point. [Laughter.]

Mr. HUMAN. If you are dealing with a fixed pot, they would each move a little closer to each other under that kind of a proposal.

Senator PRYOR. But I assume you are going to look at the $13 floor. And I assume that would be the last amount of reimbursement of anywhere and try to move that upward. Would that be correct?

Mr. HUMAN. Correct.

Senator PRYOR. Another question that I have here is, you talk about important initiatives of your office, Mr. Human, what are some of the highest priorities that you have in your office that are today unfunded or remain unaddressed?

Mr. HUMAN. Well, in terms of funding I suppose I would have to tell you that last year and this year the office has received about $1.4 million per year to fund the rural health research centers. Now we have used just over $300,000 of this appropriation last year and we will use about the same amount this year to fund the activities of the National Advisory Committee on rural health.

Most of the remaining $1.1 million was used for the research centers. That is the only funding that the office receives. Congress authorized the office, but did not appropriate funding for it. I feel that we have been very well supported in our activities by the Health Resources and Services Administration, the agency that houses us. They have provided the bulk of the costs of our salaries, benefits, costs of operation, travel. I would also thank the Health Care Financing Administration which also has helped. It has not always been easy for these agencies to divert resources to us.

Several States and associations have helped provide funding for travel and meetings we have held. So we have had a lot of different sources of support for what we have done.

Senator PRYOR. What size staff do you have?

Mr. HUMAN. Right now we have seven professionals and two secretaries; and shortly that will be up to eight when another is detailed to us.

Senator PRYOR. So you have less than ten people.

Mr. HUMAN. We will be up to ten soon.

Senator PRYOR. What is the appropriation figure again for your——

Mr. HUMAN. $1.4 million for the research centers.

Senator PRYOR. Thank you, Mr. Human.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Daschle.

Senator DASCHLE. David, were you asking, what the appropriation was for his office or for the research centers?

Senator PRYOR. For his office, actually.

Senator DASCHLE. That is what I thought you were asking.

Mr. HUMAN. Well, there is no appropriation, per se, for the office. The appropriation is for the research centers. That is why we use part of that appropriation.

Senator DASCHLE. I see.

Mr. Human, I thought that when Senator Durenberger asked you the question about what are the more priority problems we face in rural health care you did a very good job of describing it as succinctly as one can what the problems are. It is lack of access, lack of personnel. I guess I was not entirely clear as to what you thought we ought to do to address it.

I would like to ask some specific policy questions and see if you can be as specific with your response to those as you were with outlining the problem.

The first has to do with the urban/rural update. Obviously, there is an explained cost difference, and an unexplained cost difference as we consider the differential between the urban and rural payments. I can understand differentiating the costs on the basis of explained differences. I cannot on the unexplained.

Would it be the position of your office to eliminate the unexplained differences as we consider the calculation for the differential?

Mr. HUMAN. I must make a distinction here. Our office is within the Department of Health and Human Services, and so with respect to overall policy that would be recommended, our policy must be the policy of the Department as well. That is why I thought, since we have a second role of representing the rural constituency, it might be more interesting to you if I were to introduce the information from the National Advisory Committee on Rural Health which is in effect the constituency out there that we are dealing with.

Their policy has been that we should eliminate the urban/rural differential over a three-year period; and that in the interim we should take steps to assure the survival of rural hospitals that are less than 50 beds and sole community hospitals.

The Department has yet to take a formal position on those recommendations.

Senator DASCHLE. And I can understand your situation and I do not want to make it any more difficult for you to respond than we can, but we are trying to get as good a policy analysis as possible and that is a fundamental question that we have got to address this year. I think virtually, equally as fundamental, although this is arguable, is how we reimburse health care providers. I am one who views the need for Medicare reimbursement to people other than doctors as critical if we are going to get people out in rural America.

Nurses, nurse practitioners, physicians' assistants—I mean, those people are going to have to be reimbursed if we are going to do the real job of providing comprehensive care. That is more of a statement than it is a question. But I would ask whether you have any views about that?

Mr. HUMAN. I would introduce at this point another recommendation of the National Advisory Committee. It is that the Secretary should develop and implement by the beginning of fiscal year 1991, a refined measure of labor market areas to better reflect differences and hospital labor costs. In developing these labor market areas, the Secretary should implement a single national labor market definition for professional personnel.

In other words, our National Advisory Committee is taking a position which I believe is consistent with your position, that we ought to try to replace the financial disincentives for nurses, allied health workers and others to work in rural hospitals with, if not an incentive, at least a situation in which they would be paid as well as they would be if they practiced in an urban hospital.

Senator DASCHLE. But through Medicare?

Mr. HUMAN. Of course the total solution to that problem, like the problem of hospitals, would require more than changes to Medicare reimbursement.

Senator DASCHLE. Oh, of course.

Mr. HUMAN. They are recommending changes to Medicare in this case.

Senator DASCHLE. Okay. The third question has to do with the National Service Corps. In 1985 we had 1400 scholarships; in 1988 we had 220. I mean, you talk about a profound, a dramatic, change in the availability of perhaps the single best resource we have to get doctors to come to rural America. It has got to be that.

What is your view, or the Association's view, the Commission's view with regard to the National Service Corps? Would you or they support the funding level, the scholarship level, that we had in 1985? And do you view that as critical to addressing the need of availability of physicians and health care providers?

Mr. HUMAN. Senator, I am a former Acting Director and Deputy Director of the National Health Service Corps, and I have always believed that it is an important program for solving problems in rural communities. In the later years of the program we have assigned well over half of the physicians that we had available to us to rural areas because that is where the greatest needs were.

The Department has been attempting to implement a new loan repayment program. As Senator Rockefeller indicated earlier, there have been problems in the implementation of that program so far. In particular we have had difficulty in finding sufficient people who are willing to go to the areas of greatest need. In addition, it is clear as you indicate, that we are placing far fewer physicians than we used to.

The Department is constrained by the budget situation with respect to the recommendations that it can make for increasing the number of National Health Service Corps people who are funded. I think that we can certainly say, as a generalization, that this has been a program that in the past has succeeded in putting large numbers of doctors, both into intercities and into remote rural areas.

Senator DASCHLE. Well, that is not exactly the answer to the question. But they say that a good political answer is one that is long enough for you to forget the question. I am not sure that I have been given either. [Laughter.]

Senator DASCHLE. Thank you, Mr. Chairman.

Mr. HUMAN. Would you like me to extend my remarks? [Laughter.]

The CHAIRMAN. If Senator Heinz will forebear for just a moment.

Tom, I so strongly agree with that. I mean, the National Health Service Corps—a few short years ago in West Virginia we got 40 doctors a year from the National Health Service Corps; now we get 2—2. And I just really did not hear it, Jeff, in your answer. You were talking about funding levels.

All I know is when you get—The National Health Service Corps doctors—When those doctors go to a State like Kentucky or West Virginia they often end up staying there. Just like when I went there as a Vista volunteer, I wound up staying there. Just like a friend of mine in Kentucky who went there as a medical Vista, that is precursor National Health Service Corps, ended up staying there. A lot of people do that. It is a tremendous program.

In the meantime, our doctors, who graduated from our university medical schools, drawn by high tech are often lured elsewhere, but the National Health Service Corps doctors have sort of a special motivation and we need to take advantage of that. Are you saying that the funding level has gone down so severely? Is that what was in your words, that there can be no more than two to West Virginia, or were you implying something else?

Mr. HUMAN. No. I think that what happened is that we looked as a Department, and you looked as a Congress, and saw the large number of physicians who were graduating from medical schools all around the country, and we listened to researchers who told us that they would diffuse—I think that is the word that Rand and others used—increasingly into smaller and smaller communities. We came to a conclusion that relative to other priorities for which we were appropriating funds, that this one was a relatively low one because this appeared to be a problem that was solving itself. This was our view in the early 1980s.

Now we are seeing that that diffusion has its limits. It is probably time to reexamine that issue and whether or not we need to do more with the National Health Service Corps. It is probably the time to reexamine the question of State medical schools that are supported by taxes and whether we have structured the admission process and the curriculum and the opportunities for placement in rural areas during the undergraduate medical education and the kinds of programs we have to connect those graduates of medical school with communities that they might return to after their residency program.

So I think we have to deal with this both on the Federal level and the State level if we are going to increase the availability of doctors for those areas.

The CHAIRMAN. Fair enough.

Senator Heinz.

Senator HEINZ. Mr. Chairman, thank you.

Mr. Human, I think we are all enormously sympathetic to the job that is being done by nonphysician providers in rural areas. In some sense we would like to see them do more and those people who we will hear from today will be asking us to facilitate our doing more by improving on reimbursement, and permitting direct reimbursement. That may well be the case, but at the same time I am concerned that we do not have a good sense of what overall policy implications underly these decisions.

Clearly, the Department is concerned about the shrinkage of the physician base in rural areas. You mentioned that you are increasing the reimbursement floor for rural physicians, did you not?

Mr. HUMAN. This is a recommendation to the Secretary from our National Advisory Committee on Rural Health.

Senator HEINZ. I would like to expand on that a bit. Obviously, there are a lot of good arguments to expanding our reimbursement for the practitioners in rural and other areas who are now filling in for physicians. They give high quality care; it is cheaper; it is hard to get physicians to some of the areas non-physicians are willing to go; and it could improve access to care.

But I am also equally concerned about the need for protections for rural residents. In particular, without a sufficient number of physicians involved to service rural residents, there may be a lack of continuity of care when multiple providers are obtaining separate reimbursement. There might be some compromise in quality of care. This is of particular concern given that we are moving towards an effectiveness initiative in HHS but that effectiveness initiative which has quality implications, not just cost implications, is not directed, at nonphysician as well as physician providers.

There is also the issue of the unbundling of services. Many of us are concerned about rising Part B costs. It is not always clear that because you pay less for a non-physician provider, that the total costs necessarily come out that way.

Finally, there is the risk of a two-tiered health care system—one for rural residents, if any of those concerns I have are warranted; and another for more urban residents because there is more comprehensive, physician-based care in Metropolitans areas than in rural areas.

How realistic are my concerns, Mr. Human?

Mr. HUMAN. I tend to believe that these are manageable issues. I believe that there are some communities in rural America that may never be able to attract and retain the services of a physician on a full-time basis. To the extent to which we can build systems of care which involve physicians, nurse practitioners, physicians' assistants, nurse midwives, and of course nurses and allied health professionals, and to the extent to which those are disciplined systems in the way they look at the clinical practices that they are involved with, I believe that we can accomplish those objectives.

I would note that under the Rural Health Clinic Act that the reimbursement is made to the clinics and not to the individual providers. And so there is the opportunity under that act to provide the kind of discipline system that I am talking about.

Senator HEINZ. Let me ask you this. Suppose that tomorrow one quarter of all the physicians now practicing in rural areas disappear—they just decide they are leaving, they immigrate, or they retire. Would that not be an absolute health care crisis in rural America?

Mr. HUMAN. You bet.

Senator HEINZ. Within 5 years it looks like 25 percent of all rural physicians will retire. We have very little time. It seems to me, that based on what is expected, we may shrink below the critical mass of physicians that is needed to keep the rural system operating. While I commend you on increasing the floor on prevailing charges from 50 percent to 80 percent, do you think that is going to materially change the demographics and solve the problem?

Mr. HUMAN. Well, I think that something that probably all of us believe, and from what you said I would guess you would be among those people, is that if we can develop ways of increasing compensation to rural physicians so that there is no disincentive from a financial standpoint, or very little disincentive to practice in a rural area, that that will increase the numbers of physicians who elect to practice in rural areas.

Certainly, I think that is an important part of the solution. Whether it will do it alone or not, I do not know.

Senator HEINZ. Mr. Chairman, may I continue for 60 seconds more?

The CHAIRMAN. Sure.

Senator HEINZ. We have learned that while money is obviously always important, it is frequently not the reason for people choosing life styles and locations. Much depends on people's familiarity and sense of comfort with where they live. As long as medical schools attract people and train people to be specialists—85 percent of the time—who want to practice in some high tech hospital, how can we get physicians who are going to be oriented to family practice, and general medical care into rural communities?

It seems to me that there are some fairly basic issues here. Why should—Someone who has never been in a rural area chance it? You do not get taxi cabs at 11:30 on Saturday night. And more often than not, there is no place to go. [Laughter.]

Senator HEINZ. But you would not know that unless you grew up in Punxsutawney. I do not hear you addressing any of those issues.

Mr. HUMAN. I think that is an important issue. I tend to think of it as a State issue to some extent. I think that if when tax-supported medical schools came before State Appropriation Committees of the legislature each year and asked for more money, if the Appropriations Committee would ask them what they are doing to get physicians out into rural areas from their medical schools, that problem would begin to resolve itself.

I think we need to do more of that because I think we know enough now to know that we can affect the way medical schools approach these students to increase the probability that they will end up in rural areas.

For example, at the University of Washington, rural physicians are a part of the admissions committee that decides who gets into the medical school. At the University of Minnesota, third-year undergraduate medical students have the option of applying for a program under which they can serve nine to twelve months in rural areas——

Senator HEINZ. I understand that a few medical schools are doing it.

Mr. HUMAN. My point is, we have the technology. We know how we can do this and we have to——

Senator HEINZ. I agree with you. The question I asked is, what is the Administration planning to do about it, *not* what a few other people are doing about it. That is fine.

But I have run out of time and Tom Daschle was right, you are an expert at giving those political answers that he mentioned a moment ago. I cannot take any more of my colleagues' time.

The CHAIRMAN. Let me just defend Jeff for a moment, Senator, because I think what he was saying—what I thought I heard him saying—what I thought was, in fact, very helpful, and you indicated yourself, that our medical schools are training—in rural States—our medical schools are training people to aspire, so to speak, to the maximum medical opportunity. And some of us might interpret that as serving in a rural area in terms of really "making a difference." But a lot of people do not.

We discussed this in West Virginia for awhile and did it for awhile. If you go to West Virginia University Medical School and you get a scholarship of "X" number of dollars, you have to agree to serve for 2 years. So you get a reluctant person serving for 2 years and then off they go to Cleveland or Philadelphia, or something of that sort. The reason is because you have put nothing into the curriculum to build up that sense of service and capacity.

I think that is what you are saying.

Senator HEINZ. Mr. Chairman, I am not objecting to the notion that States have a role here—as they have in West Virginia and Minnesota and others. What I was trying to get out of Jeff, was an appreciation of whether he feels, at least as I do, that our reimbursement system under Medicare, is attracting medical students into specialties because they know they are going to be reimbursed lots of money for doing open heart surgery.

I perceive it as a problem. Maybe I am wrong. But I want to get a sense of what, at the Federal level, he perceives as a problem, not what the States are doing. I am all for the States. But I want to know if we are part of the problem.

Mr. HUMAN. Our office has supported a HCFA notice requesting public comments on the elimination of physician payment specialty differentials under Medicare Part B. So we have gone on record in support of the position that you are taking within the Department.

Maybe that is a better answer.

Senator HEINZ. It is. It is helpful and there is a lot more we could talk about. But the Chairman has been very kind and generous to me already, I will not prevail further.

Thank you.

The CHAIRMAN. Jeff, thank you very much. You have put a lot of pressure on the next two panels, or I have. Thanks very much for being here and you have been helpful.

Mr. HUMAN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Paul Fitzpatrick is the Assistant Chief Health Planner, Division of Planning, Policy and Resource Development, Representative, Rural Health Council, New York State. Mr. Ralph Tabor, Legislative Director, National Association of Counties of Washington, D.C.; Mr. Bruce Behringer, Executive Director, Virginia Primary Care Association and Board Member, National Rural Health Association; and Mr. John Mengenhausen, Executive Director, East River Health Care, Inc., testifying on behalf of the National Association of Community Health Centers, South Dakota.

Mr. Fitzpatrick, we welcome all four of you and perhaps you would care to begin.

STATEMENT OF PAUL G. FITZPATRICK, ASSISTANT CHIEF HEALTH PLANNER, DIVISION OF PLANNING, POLICY AND RESOURCE DEVELOPMENT, AND REPRESENTATIVE, RURAL HEALTH COUNCIL, NEW YORK STATE, DEPARTMENT OF HEALTH, ALBANY, NY

Mr. FITZPATRICK. Thank you. Good morning.

My name, again, is Paul Fitzpatrick. I am representing the New York State Department of Health and the New York State Rural Health Council. We appreciate the opportunity to present testimony on rural health care, a priority interest on the part of New York.

It may surprise many to discover that New York is a rural State. More than 3 million people live in rural areas in New York. New York has a long-standing commitment to providing opportunities for all its residents to lead healthy and productive lives. In response to the growing health care problems in rural areas in 1987, a state-wide task force on rural health strategies was created to access and develop strategies for responding to rural health care delivery problems. The report of the task force or rural health strategy has now provided the framework for responding to these issues in New York State.

In 1988 Governor Cuomo appointed a state-wide Rural Health Council and it has continued work on the task force report by implementing these strategies and recommendations. I have left a few copies of that report for your review.

There are two related and overriding issues which rural areas of New York State confront. First, there is a growing concern about the viability of the existing rural health care delivery structure. And second, and highly related, is the shortage of health personnel, particularly providers of primary care services.

In terms of the historical development, rural hospitals have traditionally served critical, often central roles in maintaining viable delivery structures. The system has become highly dependent—overly so—in many cases on the presence of the hospital. More recently rural hospitals have been grappling with issues of economic instability, case payment systems, new technologies, inadequate supplies of health personnel, shifting consumer expectations and a host of other issues. The decline of the rural hospital has forced a re-examination of the organizational structures for health care delivery. It appears essential that if rural health care delivery systems are to remain viable, a significant restructuring must occur. The independent and fragmented structure which currently exists must be reorganized to provide for far greater integration services which is not so highly dependent on the presence of the hospital.

This is not to say that rural areas should be without hospitals, but that the organization focus of delivery systems should be on the most needed services. In most communities these are primary health care and emergency care.

Restructuring of rural health care delivery systems in New York has been supported through several initiatives. I am going to talk about one in particular, but we have been working in four areas to help rural hospitals in their transition of more needed services, the development of rural health networks—which I would like to take a little bit about—the development of primary care services and the enhancement of emergency medical services.

To assure that quality health care services are accessible and delivered efficiently, New York is exploring new organizational structures to link independent service providers. The formation of rural health networks is an initiative we feel holds significant promise for rural communities. The rural health network is an involving concept which is defined as a locally-based and governed organization which has the capability of providing either directly, or indirectly, a minimum set of health-related services.

In addition to service delivery, networks functions can include administration, coordination, training, recruitment, planning, program development, capital development, fund raising and quality assurance.

New York has created a rural health network demonstration program to support this restructuring option and is currently funding 13 network sites in the State. After only a year and a half, successes have already been realized for the demonstration program. The most significant barrier we are facing with the network program is the uncertainty about long-term funding. It is essential to identify a permanent stream if the network structure can work. We are looking at existing funding streams – Medicaid, Medicare, Blue Cross, local government support, business/industry support—to provide that long-term funding.

With respect to primary care development, we have been putting in approximately $5 million a year to expand primary care through our primary care initiatives. A substantial portion of that money is going into rural communities.

With respect to emergency medical services, we have focused our efforts on the development of comprehensive communication systems and to support the predominantly volunteer-based emergency ambulance squads.

The second major issue, and one which some argue is the most critical, is the shortage of health personnel. Health personnel shortages are not, as I am sure you know, unique to rural areas. However, because of the decided disadvantage of rural areas in recruiting and retaining health personnel, the shortages are even more threatening.

The shortage of primary care physicians in particular is reading crisis proportions. Medical schools are not training sufficient numbers of primary care physicians to respond to the growing need. In fact, graduates in primary care specialties have been declining. This, and the face of the retirement of large numbers of rural primary care physicians, spells impending disaster.

The health personnel shortages are further exacerbated by unintended, yet real reimbursement differentials between urban and rural providers. Like or not, our Medicaid and Medicare reimbursement policies make it all but impossible for even the most committed individuals to locate in rural areas. These policies also provide very little incentive for medical students to choose primary care specialty areas. We must take a long, hard look at our medical education system which is failing to meet the needs of our communities. The criteria for selecting medical students, the curriculums of medical schools, the sites for providing clinical training must place greater emphasis on societal needs.

Several steps are being taken in New York to address these problems.

The CHAIRMAN. Mr. Fitzpatrick, you are going to have to draw to a quick conclusion.

Mr. FITZPATRICK. A Labor and Health Industry Task Force on Health Personnel issued a comprehensive report. That report has covered increased compensation for providers. An additional $193 million has been appropriated by the Governor to provide increased rates. We have also initiated an initiative to encourage entry into shorted professions at the high school level. We have a loan forgiveness program and a practitioner placement program where over 90 physicians have been placed in the last 3 years in rural areas.

We think that it is essential that at the Federal level we continue to provide support through the rural health care transition program. However, it is only hitting the tip of the iceberg at this point. It is essential, as we continue to respond to national health needs, that we fully recognize rural interest. It is necessary to evaluate pending health legislation to assure that efficient allocation of resources are going to rural areas.

The CHAIRMAN. Mr. Fitzpatrick, I have to go on to the next witness.

Mr. FITZPATRICK. Thank you.

The CHAIRMAN. I will do so, Mr. Mengenhausen, partially because Senator Daschle has an 11:30 hearing at which he has to be and we not only want to hear you, but I also want to give him a chance to question you.

[The prepared statement of Mr. Fitzpatrick appears in the appendix.]

STATEMENT OF JOHN MENGENHAUSEN, EXECUTIVE DIRECTOR, EAST RIVER HEALTH CARE, INC., TESTIFYING ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, HOWARD, SD

Mr. MENGENHAUSEN. Thank you.

Chairman and members of the Subcommittee, my name is John Mengenhausen. I am the Executive Director of East River Health Care in Howard, South Dakota; and I am here today representing the National Association of Community Health Centers and the more than 600 community and migrant health centers across the country.

Thank you for this opportunity to come before the Senate Finance Subcommittee on Medicare and Long Term Care and to speak to the financing and reimbursement issues facing the community and migrant health centers.

Let me start out by saying, East River Health Care operates two certified rural health clinics which I am the Director of. We operate one in Howard—a community of about 1300 people; and one in a small community of Bryant of about 1,000 people. Community health centers provide prevention orientated primary health care services close to 6 million persons throughout the nation. Services are targeted particularly to the high risk groups within the overall population. These would include perinatal services to pregnant women, their infants, the homeless, the substance abusers, the HIV, the elderly, the migrant farmworkers.

Various problems that are increasing in hindering the health centers for fulfilling their duty is that there is an ever increasing number of individuals seeking the services. In rural areas closures of hospitals and physicians' offices have left entire communities in great demand of health care services. In one specific instance that is happening now in South Dakota, the Kingsbury Memorial Hospital in Lake Preston will close effective June 1st, along with that the operating four small community clinics in surrounding communities, they will also close effective June 1st.

Federally funded community health centers in rural areas are losing ground financially. The operating expenses increased 14 percent, our subsidies of uninsured patients increased 11 percent, bad debts were up 25 percent. During this time the Federal funding for the centers increased only 11 percent—not nearly enough to cover the cost of operating the facilities.

To make a bad situation worse, the health centers suffer from inadequate reimbursement for services to Medicare and Medicaid patients. Many physicians have responded to payment freezes and cuts by reducing or eliminating their participation in Medicaid or by refusing to accept Medicare payment levels. South Dakota ranks as one of the lowest states that has participating providers in the Medicare program and this is due to the inadequacy of the reimbursements to Medicare.

Which brings me to a point. Senator Rockefeller, you should be applauded for your leadership in development the amendments to the Rural Health Clinic Act to design the enhanced participation within the Act. The National Association of Community Health Centers supports the amendments. Some of these are the simplified certification for health centers funded under the Sections 329, 330, 340 of the Public Health Service Act; clarification of eligible geographic areas modifying existing standards for rural health clinics to allow the flexibility of employment of mid-level providers; and finally, the clarification of the nurse midwives into the Rural Health Clinic Act.

Community and migrant health centers find themselves in the position of having scarce grant dollars that were provided to assure access for the uninsured patients, being used now to subsidize Medicare and Medicaid because these programs do not pay the costs of care for these beneficiaries.

Senator Chafee should also be applauded for his work and leadership in the Medicare and Medicaid amendments designed to assure the reimbursement of all the community and migrant health centers. Medicare currently pays many Federally-funded community health centers on an all-inclusive rate basis. However, this payment is based on regulatory provisions established back in 1976.

So again, the National Association of Community Health Centers supports the following amendments: [1] To strengthen the statutory basis in Medicare of the Federally-funded health centers program. It is recommended that the Federally-funded program be codified; [2] extend the applicability of the program to Medicaid reimbursement; and [3] to clarify Medicare coverage, even when charges are discounted or waived as required by law.

Finally, in closing, the National Association, as well as many of the small rural projects are familiar with Senator Pryor's legislation that he introduced—the Rural Primary Care Incentive Act of 1989. This legislation, as Senator Pryor stated, will increase the incentives for physicians to come to small rural areas and hopefully eliminate the disincentives under the tax program. Be assured that the National Association, along with many of the small rural community health centers will be working to bring that legislation to pass.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Mengenhausen appears in the appendix.]

The CHAIRMAN. Thank you.

Senator Daschle.

Senator DASCHLE. Mr. Chairman, I really appreciate your willingness to have Mr. Mengenhausen speak as he did. But I do not want to take yours or the Committee's time for questions. I am very proud to have him here representing South Dakota and the clinics, and thank you again for your leadership and your dedication to the issue.

The CHAIRMAN. Thank you, Senator Daschle, very much.

Mr. Tabor.

STATEMENT OF RALPH TABOR, LEGISLATIVE DIRECTOR, NATIONAL ASSOCIATION OF COUNTIES, WASHINGTON, DC

Mr. TABOR. Mr. Chairman, I appreciate the opportunity to be able to testify here today. At the start, I would just like to note a few facts that show what role county government is playing in delivery of health services in rural areas.

The Census Bureau's data from 1986 indicates that counties spent $14.7 billion on health care; $7.2 billion of that on hospital services. County governments are responsible for a large portion of the health, human services needs of their residents and almost all counties administer and pay part of the financing of the Federal, State, County network of social services health and welfare programs. In 19 States, Counties bear the sole responsibility to the indigent and shared in 12 more. Even in those 14 States where the State, itself, is responsible for indigent health care, Counties often end up bearing a healthy share of that responsibility.

We have several concerns for the influence and impact of the Medicare program on the services of health professionals in rural areas. We know that an earlier hearing focused on the problems associated with rural hospitals and we would like to add our voice to those in support of the elimination of the current urban/rural differential payment rates in the Medicare program. Some rural County hospitals have as much as two-thirds of their patients paid for by Medicare.

Since we did not have an opportunity to testify before today, we would like to request that we be allowed to submit some additional comments, particularly on S. 306.

The CHAIRMAN. Fine.

Mr. TABOR. Support for health promotion and disease prevention services—County Health Departments, with the traditional public health programs—prevention and health promotion, childhood immunization, maternal and child services—have a keen appreciation for the value of prevention and early intervention. We strongly support incentives for a provision of primary care services and feel that reimbursement for such services should be increased.

The work on relative value scales for physician services reinforces this approach. We would add that increased reimbursement for preventive and primary care services should be broadly available to other qualified professionals as well, especially nurse clinicians.

We would like special attention paid to the availability of home health services in rural areas.

Incentives for training and practice in rural areas—we strongly support adopting special incentives and adjustments in reimbursement rates to entice health professionals to practice in rural areas. We feel strongly that the discussion of health professionals must move beyond just the supply of physicians in rural areas.

We would like to see greater support for the use of non-physician services where warranted. We are very pleased about the bill that you are introducing on the Rural Health Clinics Act, and we will strongly support that legislation.

Many county health departments in rural areas have a single nurse clinician to meet local needs. We would like to see programs that would assist these facilities and enable them to become rural health clinics, or link them to primary care centers. This would promote access to needed services and integrated services.

We support expanding the number of teaching hospitals to conduct demonstrations to develop field clinical experience in rural areas for physicians and other health professionals. We also support promoting linkages such as the nursing demonstration program proposed in S. 306.

We would like to see support for broader reform and development of nontraditional arrangements for service delivery. In particular, we support linkages among providers at the local level, such as between primary care clinics and local public health departments. And in this regard, we would like to commend the Health Resources Services Administration on their efforts to promote these linkages. We would also like to draw it to the attention of the Committee that the National Association of County Health Officials have just recently completed a survey on some of these linkages.

All health care providers in the community must work together and have a clear understanding and agreement about the responsibilities they each have for service provision. Given scarce resources and special needs, it is critical that integrated planning and collaboration occur.

In closing, County concerns in all of these areas are in many ways little different from other provider groups. As public entities, we do not have the advantage of private sector financing mechanisms, county institutions and facilities have to rely on budgets, limited by local tax bases and are politically accountable to the residents they serve for both budgets and programs. We would like to see more attention to the development of alternatives in administering and staffing rural health care services that would merit Federal reimbursement and enhance the viability of these efforts.

Again, we appreciate the opportunity to testify and would be happy to answer any questions you may have, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Tabor.

[The prepared statement of Mr. Tabor appears in the appendix.]

The CHAIRMAN. Mr. Behringer.

STATEMENT OF BRUCE BEHRINGER, MPH, EXECUTIVE DIRECTOR, VIRGINIA PRIMARY CARE ASSOCIATION, AND BOARD MEMBER, NATIONAL RURAL HEALTH ASSOCIATION, RICHMOND, VA

Mr. BEHRINGER. My name is Bruce Behringer. I am the Executive Director the Virginia Primary Care Association. I work with underserved communities across the Commonwealth of Virginia—26 or 27 of which have a population of less than 3,000 people. In 1989 I have also been appointed by the Secretary as the chairperson of the National Advisory Council of the National Health Service Corps Program and I am a member of the National Board of Directors of the National Rural Health Association, and it is in that capacity I am speaking to you today.

All of the litany of rural needs that I was going to give as part of the presentation have already been quoted so I do not think I need to go through that again, other than just to say that I think the trends are clear. That in the future small towns and rural areas, with a high percentage of poor and elderly residents that already have too few physicians, many of whom are reaching retirement age, will be searching for new and replacement physicians from a declining pool of primary care specialists. They will have to do so without the assistance of the primary Federal program which was targeted to meet their needs. They will be competing in a reimbursement environment which rewards the choice of urban practice versus a rural practice.

The summary of what I would like to say is a summary of the testimony that I am providing. I think that Congress needs to look very carefully at the full range of programs which you are providing to enhance the policy goal of assuring the availability of health manpower in rural and underserved areas.

There are basically three strategies which you are using. The first one attempts to promote change in the existing medical education system, by enhancing the possibility of selection of primary care training programs among medical students and the choice of practice in rural areas after physicians finish their residencies. You do this through a series of programs which are already funded and authorized by the Federal government.

The second policy strategy which you have selected is to provide incentives to individual medical students and physicians to increase the supply of manpower in rural areas. You have done this through scholarship programs. You have done this through loan programs. And with Senator Pryor's bill, you are launching into the possibility of doing it through tax incentives.

A third major Federal strategy which you have embarked on is to stabilize health service delivery systems and practices in rural areas. You have done this through direct Federal assistance to practices in high need areas, for example, through the community and migrant health centers program. You have also targeted specific reimbursement assistance to publicly insured patients through the Medicare and Medicaid program and have begun to look at payment differentials for physicians who provide services in high need, underserved areas.

The recommendations that I bring to you are twofold: The first, long term recommendations and the second, short term. I believe that you need to look at all three strategies and ensure that all three strategies are cohesively working together to bring about the effect that you would like to have. I hope that you would study each of the Federal investments that you are making and analyze its contribution toward the goal of assuring availability of health care providers in rural areas.

Secondly, I would hope that you would determine what incentives and disincentives that you placed, either legislatively or administratively, within these programs which promote or restrain cooperation, coordination and program linkages to assure positive and reinforcing effects upon placing health manpower in rural areas.

Specific recommendations include: [1] Medical schools which find it within their mission, should be encouraged to adopt selective admission policies to encourage those most likely to return to rural areas to enter their schools. These medical schools should receive financial consideration for this. [2] Congress should continue to support specific programs to enhance medical school and residency program experiences in rural areas. [3] Within the framework of research already proposed, and funded by the Federal government, special consideration should be given to enhancing and supporting primary care research. [4] Reconsideration should be given to re-expanding Federal financial support for medical students and physicians through service contingent programs targeted toward high need health manpower shortage areas in rural areas. [5] In the short term Medicare policies, which reduce the urban/rural differential payments to physicians, should be expanded. The incentive payments for physicians programs should be expanded. And that in the long run, hopefully, Congress will look at eliminating those differentials and, hopefully, look at the RVS system for reimbursement through Medicare.

Thank you.

[The prepared statement of Mr. Behringer appears in the appendix.]

The CHAIRMAN. Thank you, Mr. Behringer.

Senator Pryor had to leave, but he specifically wanted to ask you, and, I think you already have, but we will do this again, to comment on his Rural Primary Care Incentives Act that he introduced last night. I believe you have already referred to that.

Mr. BEHRINGER. Yes, sir. By providing tax incentives as a third method of enticing physicians into rural and undeserved areas, you are launching, as he said, into a new vein of Federal commitment toward assisting rural communities. The service contingent programs have proven to be very successful. If you will look at the service contingent program of the National Health Service Corps scholarship program, you will see that 15 percent of the physicians who are serving in small towns in the country right now came through that program, providing another mechanism, providing another——

The CHAIRMAN. Through the National Health Service Corps Program?

Mr. BEHRINGER. Yes, sir; through the National Health Service Corps Scholarship Program. It has been a highly successful program.

By providing tax incentives I think you are providing another mechanism which will reach a different type of physician who would not want to sign an obligation and need a scholarship, perhaps, all the way through medical school. So we support that.

We also would hope that the Senate would consider, not just what is designated as a HMSA one and a HMSA two, or a health manpower shortages areas number one and number two, but also consider all health manpower shortage areas for these programs.

The CHAIRMAN. Just one more quick one. Does Highland County, Virginia, incidentally have a rural health clinic?

Mr. BEHRINGER. No, sir.

The CHAIRMAN. It does not. Neither does its neighbor, Pocahontas County on the West Virginia side?

Mr. BEHRINGER. No, sir.

The CHAIRMAN. That is a challenge to us, is it not?

Mr. BEHRINGER. There is only one physician practicing in Highland County right now. He is an elderly physician. And, in fact, I have been in touch with the closest hospital there to work with that County, and Highland County, perhaps to set up a system of care, including rural family practitioners tied into the hospital.

The CHAIRMAN. In Pocahontas County, right across the border in West Virginia. —We have a farm there so I have what I would call a special interest. We did have four young children; we still have two young children. In any event, when we go there, we are very much aware that there is not an extended health network.

Now, in fact, several years ago—a number of years ago—there was a couple, a Dr. and Dr. Jones, who came into northern Pocahontas County which is huge and—it is an enormous area—they came there to practice. They came there specifically because they loved the rural area. In other words, everything seemed to be perfect. In fact, you know the scenic railroad—they were railroad buffs. They loved real medical practice. They were both married. They bought a lovely rural, quaint home—a farm home—and everything seemed to be going well except for the fact that they could not make it financially and they had to leave. And there is nobody there now.

What would be your guess as to what happened to them financially, and why, and what we could do about it?

Mr. BEHRINGER. I think it has to be clearly understood in rural practice that Medicare and Medicaid, or publicly insured individuals, may consist of up to 30 or 40 percent of a physician's practice. There are a large number of uninsured individuals who reside in rural counties also. One aspect could be the low reimbursement rate—reimbursement rates that do not cover costs, as you have already noted—from the public insurance of Medicare and Medicaid.

The second could be the fact that there are a large percentage of poor people in the area and those physicians saw to it that those people had a source of care. For those physicians—and I believe in my heart—that most physicians in this country want to take care of everybody who walks through that door. For those physicians who do that, they run the risk of not being able to afford running that practice for a long time.

So I think that access to care, and those who believe in access to care, and practice access to care, run that risk of not only losing money on Medicare and losing money on Medicaid, but also giving away a lot of indigent care. I suspect that could be a reason why they left.

The CHAIRMAN. So when you combine the lower payments under Medicaid, the high number of Medicaid patients, the high number of patients who were simply not able to reimburse at all, and then the 25 percent, presumably, in Highland and Pocahontas County, maybe more, those who are Medicare recipients, it gets very hard for them; does it not?

Mr. BEHRINGER. Yes, sir.

The CHAIRMAN. And you would specifically correct that by doing what?

Mr. BEHRINGER. Well, I think the first—a very good first step would be to take a very honest look at what you are reimbursing primary care physicians through the public insurance of Medicare and Medicaid. By bringing up your reimbursements under a relative value scale to the value of what those primary care physicians provide——

The CHAIRMAN. So it is your feeling that if we implement a relative value scale, and family physicians in fact do gain, as in fact they appear to gain—although that is not entirely clear everywhere, HCFA gives hints—but, nevertheless, that is the general sense.

Would it be your feeling that in Highland County and Pocahontas Counties of Virginia and West Virginia that increases in salary, the reimbursement through Medicare, et cetera, that that could make a substantial difference, even enough to keep a Dr. and Dr. Jones, both practicing physicians, in a Pocahontas County?

Mr. BEHRINGER. I think that would be one approach. A second approach—and again, Congress should be congratulated, as should the States, who have selected to take the options under Medicaid would be to increase the number of people who would be eligible for Medicaid by increasing their elegibility limits for services. For example, you have made pregnant women and children under 100 percent of poverty and then 130 percent and then 185 percent of poverty eligible for Medicaid.

The CHAIRMAN. But is it not really also true—and Senator Durenberger jump in here whenever you want—that we really do a very poor job in Medicaid? In fact, one of the risks we run is to sort of put more tasks on Medicaid, even as we are not funding it, and the States are being given impossible tasks.

Mr. BEHRINGER. I think that you would hear from the National Governor's Association that that is very true. That, in fact, Congress does provide for more options, not necessarily increasing the size of the national budget, however, for that program.

The CHAIRMAN. Senator Durenberger.

Senator DURENBERGER. Mr. Chairman, thank you.

On the subject we were just visiting—then I have sort of a general question I would like to ask of all the panelists.

And because the Chair in particular has a deep concern for the availability of medical professionals, let me ask the same question about the Dr. and Mr. Jones, or the Dr. and Mrs. Jones, as the case may be, by explaining what I see happening in my area. When I run for reelection half my people live in the Twin Cities and so I spend, you know, 70 percent of my budget on Twin Cities television; but the other 30 percent gets to the other half of the people in the State and I have to spend that in places like Sioux Falls, South Dakota, Lacrosse, Wisconsin, Fargo, North Dakota, Grand Forks, North Dakota. I tell you that because that is also where the medical professionals are going in rural Minnesota.

That is also on an increasing basis where Minnesotans, from whence Minnesotans are getting their medical service. One of the reasons that I—I had a letter here from a doctor who is the president of a clinic in rural Minnesota which is no longer here. But one of the reasons that a lot of the doctors are gathering in Sioux Falls, and Fargo, and within our States in the regional referral centers and so forth, has a lot to do with quality of life and availability of a lot of other things, other than that that they can get in big cities and they believe they cannot; and we know they cannot get in some small town.

So what it seems to me is happening in America is that the notion that you can bring a doctor to every town is no longer realistic if you expect him to bring his family and everything else—all of his needs to be satisfied in that community—it cannot be done; and the doctors know that it cannot be done.

So one of the things we seem to be striving for and one of the things that the doctors seem to be telling us, as well as a lot of other professionals—I do not mean to use just the doctors—is, give us some other way to be in every town. In other words, maybe we live in Sioux Falls, or we live in Willmar, or we live in Marshall, or Hibbing, places like that in my State, but we would love to come on Tuesdays and Thursday afternoons, or we would love to be there for you when you need us in some other fashion.

So the issue is not just how to get a doctor in every town; the issue is how to make sure that the access is there when we need it and we can keep improving the quality of that access. I just want to see if you agree with that. But one of the things they need is some kind of a health center, or some kind of a facility, or some place when they come to a little town of 200 people or whatever the case may be, which now has a hospital but is in danger of losing that hospital, they need something there as part of that.

Just in a general way, in terms of how we think about structuring programs, is that one of the things that is going on in the country right now.

Mr. **Behringer**. I think we have to be consistent with policies. One of the issues involved is access generally versus availability specifically. You hit the nail on the head that not every town of 200 people is going to be able to afford a physician. One of the prevailing rural attitudes that I have worked with for a number of years now is that every community that wants a physician may not be able to afford to have a physician. One of the concerns that I always express to communities who are looking for those physicians is whether or not they will support a physician who comes.

I do not want to make this sound like blaming the victim. In some rural communities many people would prefer to go to the Hibbings and prefer to go to the big city, because they feel the health care is perhaps a little better there than it might be in the small town.

The big issue, I think, is communities pulling together and supporting those medical care providers that they do have. And the second part, in terms of a policy, has to do with making sure that the Hibbings work with the small towns of 200. Rural hospitals have been an excellent vehicle for doing that; consortia of rural community health centers have been an excellent way of doing that; health centers working with public health departments and hospitals working with public health departments have been a way of doing that; and medical schools working with rural communities have been a way of doing that also.

Senator **Durenberger**. The point of the question is not just to say, you know, before we get into Federal mandates on rural health education, let's not get too carried away with the notion that we can have a doctor in every town and so forth.

The other point was that if the better system is that the doctors may be in the larger towns, but they are going to be also out in those smaller towns, a payment system that says, if you do a procedure in the little town, you only get 75 percent of what you get if you do it in the bigger town, at some point discourages what we would like to encourage. Which is, it should not make any difference where the person lives or even where the treatment is rendered. If you are a certain specialty, operating on a certain procedure, you ought to be able to get "X" dollars.

One of the problems with this incredible disparity that we experience in the reimbursement systems is just that. That it could discourage one of the best things we have got going, which is the doctor may not live in town but he is there for you. In fact, an even better doctor or series of doctors will be there for you when you really need them because they do not have to make a sacrifice to come to you when you really need them. And right now they are being asked to make these sacrifices in the way the reimbursement system works.

Mr. **Tabor**. Senator, could I just comment on your earlier question where you were talking about the nurses and the other medical professions being available to the smaller communities. We have a mechanism out there that is there. It is already operating and that is our local public health departments. In terms of trying to have facilities available for further clinics and to broaden the service, it would be very easy for a County government to find the facilities because they already have the facilities in the small communities. We have had to be in decentralization for a long time in there, particularly in our large western rural counties.

The other thing is, on the points we made in our testimony is that we really think that the rural health clinics should have much more linkages with County health departments and in many cases, the County health department could be running them. And it does not address the question about physicians, but certainly in terms of having other medical care and more access available, we have really got to try to promote more of these linkages.

In many cases where that same County may be participating in the cost or running the hospital, it is going to save them money, too.

Mr. MENGENHAUSEN. If I could just comment on that same line, Senator. What you are suggesting is what we do and the two clinics that I operate—the rural health clinics—we have full-time mid-level providers and we contract with a private physician group in a larger community—it is Madison, South Dakota, that brings out their physicians 1 day a week, which they need to be on site, mandated by law for four hours. But we have a rotating group that comes. One week we will have the family practitioner; one week we will have the OB; one week we will have the internists. It works quite well.

So the Rural Health Clinics Act, as a whole, I think in building upon that will just do precisely that. It will help bring out the physicians into the small areas.

Senator DURENBERGER. Yes. You are from Howard?

Mr. MENGENHAUSEN. Yes.

Senator DURENBERGER. I have been to Hettinger, North Dakota, which reaches in the northwestern——

Mr. MENGENHAUSEN. Right, into Isabel.

Senator DURENBERGER. And I am riding on the plane the other day with the guy who is coming in from a farmers union meeting who is also on the Board of the Hospital of Lemmon. Now Lemmon is a fairly large size South Dakota community.

Mr. MENGENHAUSEN. Right.

Senator DURENBERGER. In Lemmon they are taking this 52, 53, or 54 bed hospital, converting it into a 52-bed nursing home with four hospital rooms, so they can keep their hospital status. The Hettinger Clinic is a wonderful operation, like I am sure yours is. I just have not seen yours.

That at some point gets endangered when these communities are forced, in effect, to take down those hospital beds and substitute something else. It makes it more difficult for the folks at the Hettinger Clinic or the East River Health Care, Inc., or something like that, to do some of the things in Lemmon that would be a lot cheaper to do there than taking them to Bismarck, North Dakota or to Rapid City in the case of Lemmon, which is, 194 miles away, I think, to Bismarck from Lemmon and you have to go 140-some miles to Rapid City in the other direction.

Mr. MENGENHAUSEN. Right.

Senator DURENBERGER. But they are being forced by in part the reimbursement system, to take down all of those beds. The community serves I think either 6,000 or 12,000 people.

The CHAIRMAN. Let me just add one question on top of that. Then we have to go to our next panel and I apologize.

To you, Mr. Mengenhausen, a third of all rural community health centers are certified to be rural health clinics you have so said. Let me ask a couple of questions. What is the advantage of a community health center being certified as a rural health clinic? As the administrator of a community health center that is also designated rural health clinic, do you feel that the current certification is cumbersome and burdensome? If my bill is adopted, how many more community health centers would you predict would seek certification as rural health centers?

Mr. **Mengenhausen**. On the first part, Senator, the certification to become a rural health clinic is quite burdensome. A lot of the things that we need to do to become certified we already do under the Community Health Center Act. So there is no need to go through the whole State survey when it is already being done for somebody else. The State comes in and mandates that so and so provides these type of policies and whatnot, one that is already being accomplished under the guidelines of the Department of Health and Human Services.

So, yes, that would be a major plus. And, the number of community health centers that may become certified I guess in just guessing, in my region alone, could easily be another 15 to 20; and my region is Region 8, which encompasses North Dakota, South Dakota, Montana, Wyoming, Colorado and Utah. And we have had some—since they have raised the cap, we have had some strong interest from a lot of community health centers, but they are still running up against—as we just mentioned—the survey.

The actual numbers, the National Association can get back to you. They do have a task force that is looking at just that, working with community health centers, trying to get them into the program. I think we can get you some better definite figures at a later date.

The **Chairman**. We would like to have them.

The **Chairman**. Do you other gentlemen agree with the thrust of his answer that there would be significantly more rural health centers?

Mr. **Fitzpatrick**. Yes.

Mr. **Behringer**. Yes.

The **Chairman**. I thank you all very much and apologize for keeping you so long, or for keeping you so long before you came up to testify and I apologize even more to the next panel.

Ms. Pat McGill, who is Director of Nursing at the Charleston Area Medical Center—that is Charleston, West Virginia, not Charleston, South Carolina—and she is testifying on behalf of the American Nurses Association; Mrs. Dani Cossette, Chairman of the Practice Committee, American Association of Nurse Anesthetists, from Kansas; Jan Towers, President of the American Academy of Nurse Practitioners, Pennsylvania; Tom Harward, who is a Physician Assistant at the Belington Clinic, testifying on behalf of the American Academy of Physicians Assistants; and, Mr. David Bush, Ph.D., Vice President, Spectrum Learning, testifying on behalf of the American Psychological Association, Great Falls, Montana.

And I had, Dr. Bush, a special apology from Senator Baucus who could not attend because he, himself, is chairing another Committee and wanted me to apologize to you.

So, Pat McGill, might we start with you.

STATEMENT OF PAT McGILL, MSN, RN, DIRECTOR OF NURSING, CHARLESTON AREA MEDICAL CENTER, TESTIFYING ON BEHALF OF THE AMERICAN NURSES ASSOCIATION, CHARLESTON, WV

Ms. McGILL. Good morning. Mr. Chairman, I am Patricia McGill. I am a cardiovascular clinical nurse specialist and Director of Nursing at the Charleston Area Medical Center in Charleston, West Virginia.

I would like to thank you on behalf of the American Nurses Association and the Association of Operating Room Nurses for this opportunity to address rural health care issues. We find this topic especially timely in light of the severe nursing shortage currently facing our country and its impact on access to health care in rural areas.

More than 25 percent of all Americans live in rural areas, and yet rural America has only 18 percent of the Nation's nurses. A shortage of physicians and other health care providers also exists in rural areas.

However, there are four categories and nurses in advance practice that have played a crucial role in extending physician services in rural areas where routine access to physician services has not always been available. Nurses in advanced practice include nurse practitioners, certified nurse midwives, clinical nurse specialists and certified registered nurse anesthetists.

In 1986 an Office of Technology Assessment report noted that nurses in advanced practice have expanded access to care by their willingness to locate in rural and underserved areas to a far greater extent than physicians. For example, nurse practitioners expand access for school children and the elderly in nursing homes. Certified nurse midwives provide maternity care. Clinical nurse specialists, by providing follow-up care in the home, allow the early discharge of very low birth weight infants. And certified registered nurse anesthetists provide 70 percent of anesthesia care in rural areas.

According to the 1988 West Virginia Board of Examiners statistics, West Virginia has licensed 70 nurse practitioners, 3 certified nurse midwives, 40 clinical nurse specialists, and 201 CRNAs. There are also other problems in rural areas.

Since 1984, 159 rural community hospitals have been forced to close. Of the remaining 2700 rural hospitals, as many as 600 face closure. In West Virginia, 6 rural hospitals closed in just the past year and a half. A January 1989 study conducted by the West Virginia Hospital Association cited rural location as the number one reason for inability to recruit nurses.

The HHS Nursing Commission has estimated that 9 percent of rural hospitals were forced to close beds as a direct result of the nursing shortage. In addition, many rural residents face the financial burden of their health care alone because they are self-employed and do not have employee health insurance.

In 1986, 15.9 percent of West Virginia's population had no insurance and that included 132,000 working adults and their families. In recent years there have been numerous Federal initiatives, rural initiatives, intended to alleviate these problems. While our written testimony addresses community and migrant health centers, the National Health Services Corps, Emergency Medical Services, and the Nurse Education Act, I would like to highlight specific rural initiatives within this Committee's jurisdiction.

Rural Health Clinics. Currently a nurse practitioner or a physician assistant must be employed at least 60 percent of the time that the rural health clinic is operated for patient care in order to qualify for reimbursement. Some clinics, however, are unable to obtain or retain the services of a nurse practitioner or a PA. There is also a lack of publicity and information about the rural health clinic program and there are administrative delays and burdensome reporting systems which make it difficult to establish a rural health clinic.

We recommend, number one, that the percentage of time that a nurse practitioner or a physician assistant must be employed by a rural health clinic be decreased from 60 percent to 50 percent in order to qualify for reimbursement. Certified nurse midwives, in addition to nurse practitioners and physicians assistants should be recognized as a type of practitioner that rural health clinics may employ and receive reimbursement for their services. Incentives should be provided for States to participate.

The criteria for rural health clinic designation should be revised and streamlined so that there is a certification for areas where there are rural shortages.

Infant mortality. The United States ranks nineteenth in the world in infant mortality. Rural areas have an average infant mortality rate of 15 deaths per 1,000 live births. We recommend a change in the Medicaid and the poverty level to increase access to maternal child health programs.

Thank you for this opportunity to participate.

The CHAIRMAN. Thank you, Pat.

Tom, I am going to exercise my prerogative as Chairman to call on you next because you are from West Virginia. You are representing the American Academy of Physician Assistants. I have to say that I greatly admire you and those in the audience should know two extraordinary things about you. One is that you are going to be officially recognized by the American Academy of Physicians Assistants as the Physician Assistant of the Year, number one; and number two, you have 15 children. [Laughter.]

Mr. HARWARD. Thank you, Senator.

The CHAIRMAN. And we now await your testimony.

Mr. HARWARD. I think first I would like to defend myself on the 15 children—11 are adopted. I could not ever have anyone accuse me of putting my wife through 15 pregnancies. [Laughter.]

[The prepared statement of Ms. McGill appears in the appendix.]

STATEMENT OF TOM HARWARD, PHYSICIAN ASSISTANT, BELINGTON CLINIC, TESTIFYING ON BEHALF OF THE AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS, BELINGTON, WV

Mr. HARWARD. Mr. Chairman, on behalf of the American Academy of Physician Assistants, and the 20,000 physician assistants we represent, I want to thank you for this opportunity to present our views.

As you have indicated, my name is Tom Harward and I am a physician assistant from Belington, West Virginia, where I practice and serve as the administrator of our clinic. This is a Federally-certified rural health clinic. Finally, as you may recall, when you were Governor of West Virginia, you appointed me to the West Virginia Board of Medicine, where I continue to serve and am Chairman of the Physician Assistant Committee.

For the past 11 years, working under the supervision of a family practitioner, I have been the principal health care provider for Belington and surrounding communities in Barbour County. With both high physician turnover and shortages in our County, our clinic has been an important asset in maintaining stable care for our community.

Mr. Chairman, I need to state from the outset that my personal rural health experience is limited to Belington in particular and West Virginia in general. I point this out because in talking with my colleagues in other States and Regions, I find that we in West Virginia are somewhat unique. We have a Medical Practice Act that encourages the utilization of physician assistants in rural practices such as mine; and we have a State Health Department that both understands and encourages the utilization of the Rural Health Clinics Act.

The Academy has prepared a chart showing the number of Federally-certified rural health clinics [RHCs], the number of Counties eligible for an RHC and the total number of Counties in each State that have health manpower shortage areas and whether or not they are rural.

I would ask that this chart be inserted into the record.

The CHAIRMAN. It will be.

[The chart appears in the appendix.]

Mr. HARWARD. As you can see from the chart, when you do see the chart, West Virginia has done quite well in terms of getting clinics certified. But as successful as we have been, it is clear that more needs to be done on a nationwide basis. As you examine this chart, you will see that there are some States—most notably Texas, Michigan, North Dakota, Indiana, Arkansas and Louisiana—that have no rural health clinics. This, despite sizeable portions of their State that are deemed eligible.

Much of the shortfall can be attributed to a poor State understanding of the Rural Health Clinic Act. It is for this reason that the Academy believes that one of the most important improvements you are recommending in the Rural Health Clinics Act is the requirement that the Office of Rural Health provide both general and technical information to entities seeking certification as rural health clinics.

Over the past ten years the Academy has received numerous inquiries from individual PAs about the particulars of rural health clinic formation. We often find it is necessary to refer these individuals to the State Agency charged with administering the program, only to find out the State Agency knows little, if anything, about the Rural Health Clinics Act.

Two years ago when the Academy staff was encouraging members of the House and Senate Rural Health Caucus to look at the Rural Health Clinics Act, it was almost impossible to find anyone in the Federal bureaucracy who knew anything about the program. There was no one who understood the policy implications of the Rural Health Clinics Act or how it might be used more effectively in the fight to improve access to health care in rural America.

This point cannot be overlooked, Mr. Chairman. Until the Rural Health Clinics Act is fully incorporated into the overall Medicare/Medicaid philosophy, it will continue to function as an unwanted stepchild of the Medicare/Medicaid bureaucracy.

The Academy applauds your initiative in this area and we believe it—more than any other change you might recommend—will have a positive effect on the image and growth on the Rural Health Clinics Act.

On the other proposed changes in the Rural Health Clinics Improvement Act of 1989 our comments are equally positive. First, we strongly support a reduction in the RHC staffing requirements from 60 to 50 percent. While this might seem like a minor change to some; it is really rather significant. At the present time, several PAs are attempting to staff, under physician supervision, two rural health clinics in different communities. Under these guidelines, these individuals must put in extra long days in order for the clinic to maintain its RHC status. By lowering the staffing requirements from 60 to 50 percent you will allow these dedicated individuals to work more normal hours.

Secondly, we support the PA/NP waiver proposed in your bill. Frankly, we wish this were not necessary. But the fact of the matter is that there is a tremendous shortage of physician assistants and nurse practitioners and we are simply not able to keep up with the demand. We do believe that in applying for the waiver the clinic must demonstrate that it has made a good faith effort to find and employ a PA or nurse practitioner and, further, that the waiver be temporary. In addition, we believe that the clinic must make a continuing effort to find such staff.

In addition to the enactment of the Rural Health Clinic Improvement Act of 1989, we would also strongly request that the Committee enact Senate Bill 461, legislation introduced by Senator Grassley, authorizing Medicare coverage for physician assistant services in all currently uncovered practice settings.

You have personally supported and co-sponsored this legislation in the past, Mr. Chairman, as have a significant number of the Committee. The importance of Senate Bill 461 and its counterpart, House Bill 1175, is evidenced by the chart I introduced earlier.

As you can see, Mr. Chairman, there are nearly 600 Counties which are either totally or partially designated health manpower shortage areas, but that cannot benefit from the rural health clinic program because they are not designated as rural. However, many of these communities presently designated as urban are, in fact, very rural. The problem is that the present method of determining the difference between urban and rural puts many of these communities in the wrong category.

Your interest in addressing the serious problems in rural America is greatly appreciated by those of us who are charged with providing health care. Your willingness to speak out on this important issue means a great deal, not only to the practitioners but also, of course, the patients we serve.

Thank you, Mr. Chairman.

The CHAIRMAN. Tom, thank you very, very much.

[The prepared statement of Mr. Harward appears in the appendix.]

The CHAIRMAN. Dr. Bush.

STATEMENT OF DAVID W. BUSH, Ph.D., VICE PRESIDENT, SPECTRUM LEARNING INC., TESTIFYING ON BEHALF OF THE AMERICAN PSYCHOLOGICAL ASSOCIATION, GREAT FALLS, MT

Dr. BUSH. Thank you.

First, Senator, I would ask that you express my appreciation to Senator Baucus for not being here; and he can gain my forgiveness by co-sponsoring Senate Bill 100.

On behalf of the 90,000 members of the American Psychological Association, I appreciate the opportunity to testify this morning. I hope to expand your awareness of the inadequacies in the provision of mental health care to elderly through the Medicare system and also provide what I hope are thought provoking and solution-oriented suggestions.

Our national President has called for us to be a service oriented country and I believe that psychologists are now equipped to answer that call, particularly on behalf of the elderly and those who reside in rural Montana.

Presently, approximately 20 percent of the population in rural counties exceed the age of sixty-five. We also have a significant exodus of youth from our State. This leaves us with a depletion of taxable resources, and as a result 23 of 27 rural hospitals in Montana now are in serious financial condition and face possible closure.

With the ever increasing health care costs and costs of insurance for physicians as well as patients, we find that more and more physicians are leaving the rural practice and moving to urban areas. Some find Montana's expansion big sky country very attractive. However, we find that for a senior citizen who is seventy years of age, travel from Circle to Billings or Great Falls, is rather formidable, especially in February or March.

We find that qualified clinicians are increasingly difficult to attract to rural facilities. And in the mental health arena, those on Medicare are forced to see general practitioners who might have little training in the diagnosis and treatment of emotional disorders. The alternatives are to either travel the extreme distances or to stay home and suffer. Where in the fact, the farm ethic of self-reliance has been admirable, we find that this places an unnecessary dilemma on individuals who already struggle with the stigma of seeking mental health services.

Presently in our State we only have 36 psychiatrists. This leaves 80 percent of the State, 63 percent of the rural population and 44 percent of our elderly unserved. On the other hand, there are 130 licensed psychologists who would cover an additional 13 Counties and that would be an additional 15,000 Medicare recipients. Simply recognizing duly qualified and licensed psychologists as providers would reduce the access problem by 30 percent in our State.

Now some raise concerns about the qualifications of a psychologist to diagnose and I would like to turn to my private practice to address those critics. Recently, I was referred a sixty-four year old patient who had been seen by a family doctor, secondary to unusual behavior. He was diagnosed a paranoid schizophrenic, placed on anti-psychotic medication, and his course declined. He was eventually hospitalized in a residential care facility. I received a neuropsychological consult and found evidence for a possible seizure disorder. I referred him to a neurologist who discovered that he did, in fact, have a complex partial seizure disorder. He was placed on anti-convulsants and when I saw him in follow-up he said, "This is the first time in years that my mind hasn't been confused. It's like someone finally fine-tuned my set and the picture is at last clear."

Duly trained, qualifying licensed psychologists are competent to practice within the scope of their license and they compliment, rather than compete, with their medical counterparts.

We would like to suggest the following reforms for the Medicare system. First, that you recognize licensed psychologists as independent practitioners in a Medicare system, significantly improving access to appropriate services for rural elderly.

Second, that you encourage coalition building between professional organizations, such as we are presently organizing in our State between the Montana Psychological Association, AARP, aging services within the State, et cetera.

The synergistic effect of a united effort will help us to provide creative solutions through support groups, such as Parkinsons and Alzheimer's support groups, which I donate at least one to 2 hours a month to in providing workshops on communication, coping with chronic pain, making it through the holidays after the loss of a significant other, et cetera.

We find that, in rural Montana, such coalition building is absolutely essential and we think it would be facilitated by Medicare's recognition of psychologists as competent professionals.

Third, we would support the funding requests that have already been mentioned for the elderly, including alternate cost effective programs such as Home Health Care, which could be provided if there was consultation for those that would serve the elderly in their homes.

Finally, and most importantly, let's not deprive those whom we serve in the effort to serve themself, namely, the elderly. Montana is rich with well educated, energetic, creative and contributing seniors who are willing to help each other. Perhaps with minimal Federal support projects, such as a senior watch, could be implemented, in which they called each other each day, allowing there to be a supportive network where they could help—not only in terms of their emotional needs, but alert qualified professionals if a problem were to arise.

I guess our plea to you is that you would help us to help them to help themselves.

Thank you very much.

The CHAIRMAN. Thank you, Dr. Bush.

[The prepared statement of Dr. Bush appears in the appendix.]

Dr. Towers.

STATEMENT OF JAN TOWERS, Ph.D., PRESIDENT, AMERICAN ACADEMY OF NURSE PRACTITIONERS, BIGLERVILLE, PA

Dr. TOWERS. Thank you.

My name is Jan Towers. I am a practicing nurse practitioner in rural Central Pennsylvania. I am here on behalf of the American Academy of Nurse Practitioners to address the need of rural citizens to access quality health care with particular reference to the recruitment and use of nurse practitioners in rural health care settings in this country.

It has become clear that the current health care needs of our rural population are profound. Not only do these groups of people have higher concentrations of children under the age of eighteen and adults over the age of sixty-five, they have higher levels of poverty, higher levels of maternal and infant mortality and higher rates of chronic disease than people in urban areas of the country.

The status of these needs becomes more acute when one considers not just the current but the future health needs of the population. It is reported that by the year 2000, the percentage of the population most in need of health care, the poor and the elderly, will have increased substantially. Nurses are the major health care providers for these populations in both acute and ambulatory care settings.

According to preliminary findings from the national survey conducted by the American Academy of Nurse Practitioners, nurse practitioners practice in rural areas in all 50 states. The majority are family nurse practitioners, followed in number by women's health nurse practitioners and pediatric nurse practitioners. In rural communities, nurse practitioners are found predominantly in free-standing primary care settings and public health clinics and in small communities one may find nurse practitioners in private practice with physicians.

Seventy-three [73] percent of the nurse practitioners functioning in rural areas have elderly people among their patients and 83 percent see children under the age of twelve. Nurse practitioners are needed to provide primary care to mothers, infants and children, as well as to the elderly everywhere, and particularly in the areas unable to attract and retain physicians. The quality and cost effectiveness of their care has been documented in numerous studies.

Yet, with this documented track record for quality and cost effective care, only 13 percent of the nurse practitioners in very rural, and 10 percent in semi-rural areas, report that they see patients in nursing homes, and only 29 percent in both groups having hospital privileges of any kind.

In addition, of the 48 percent of those practicing in very rural areas and 35 percent in semi-rural areas who provide services that are reimbursable through third party payment, less than 5 percent obtain direct reimbursement for their services. Given the above data, the barriers to retaining and increasing the utilization of nurse practitioners in rural areas becomes obvious. The quality of care and cost effectiveness of nurse practitioners have been demonstrated over and over again. Yet their inability to obtain Medicare and Medicaid reimbursement, their inability to practice in extended care facilities and to provide services in rural hospitals tie the hands of these highly competent health care providers.

Such barriers make functioning in rural settings frustrating and consequently potentially undesirable to would be practitioners. We feel that these barriers could be easily changed.

Accessing quality cost effective health care is an important issue to nurse practitioners. The Academy, therefore, endorses the initiatives in the rural health legislation currently being introduced by you, Mr. Rockefeller. The Academy also endorses the development of medical assistance facilities in rural areas unable to support the presence of a full-service hospital.

Additional legislative solutions which could contribute to the alleviation of problems of access and contribute to the recruitment and retention of nurse practitioners in rural health care include, first of all, one of the things that has already been mentioned, providing for publicizing the availability of rural health care clinics, both certification and the reimbursement mechanisms to nurse practitioners and facilities interested in utilizing nurse practitioners.

In our interaction with nurse practitioners throughout the country we, too, are acutely aware of the fact that little is known among nurse practitioners about these clinics and the method for applying for them.

Another one is the provision of Medicare reimbursement for those medical services being provided by nurse practitioners in extended and primary care facilities other than rural health clinics. Under the current law, elderly patients, other than those being seen in Federally-funded rural health clinics who wish to see a nurse practitioner are forced instead to see a physician in order to have their care reimbursed by Medicare.

The provision of Medicare reimbursement to nurse practitioners for medical services rendered would not add to the expense, but rather reduce the cost of providing health care to the elderly in rural areas. Record and Denton in their investigations calculate the savings of $300 million to $1 billion per year if nurse practitioners were used to provide the services they are qualified to provide.

A third solution is the recruitment of nurses from rural areas into nurse practitioner programs via scholarships and educational stipends in order to facilitate their return to those areas; and ensuring that the 1989 funding levels for nurse practitioner education that were authorized in the Nursing Shortage Reduction and Education Extension Act of 1988 are appropriated so that more nurse practitioners may receive stipends and assistance to meet education costs that they incur.

Other possible ways to contribute to the solution would be the provision of GME funds to agencies and institutions in rural areas who prepare nurse practitioners to work with underserved populations; providing opportunities for increased access to continuing education through scholarship and increased funding for programs for rural health settings would also help; as would the inclusion of nurse practitioners in demonstration projects involving the use of telecommunications in patient care and continuing education in rural areas. Several initiatives are discussed for physicians that should be broadened to include other health care providers involved in rural health care.

Nurses and nurse practitioners are particularly well prepared to care for the underserved, for mothers and children, and the elderly. Large segments of our nursing curriculums are devoted to helping students to understand and implement care in settings among patients and clients with limited resources, financial and otherwise.

In addition, they are well suited to care for mothers and children and the elderly due to their dual preparation in both nursing and medical arenas. Nurse practitioners——

The **CHAIRMAN**. Dr. Towers, you will have to conclude.

Dr. **TOWERS**. I am just about finished.

Nurse practitioners are prepared to assist these populations by managing their chronic and acute medical conditions as well as assist in attaining and maintaining a high quality of life by guiding and supporting their health promoting activities, both physical and emotional.

In summary, nurse practitioners are viable and valuable health care providers in rural communities. With additional enabling legislation such as that described above, the ability to recruit and retain those providers will be greatly enhanced.

We wish to thank the Finance Committee for its concern for the health care of the people in rural America, for we too are concerned about the ability of these people to access quality, cost-effective health care, both now and in the future. We would like to help and appreciate the opportunity you can provide to allow us to do that.

The **CHAIRMAN**. Thank you, Dr. Towers.

[The prepared statement of Dr. Towers appears in the appendix.]

The **CHAIRMAN**. Ms. Cossette.

STATEMENT OF DANI M. COSSETTE, CRNA, CHAIRMAN, PRACTICE COMMITTEE, AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, SALINA, KS

Ms. **COSSETTE**. Mr. Chairman, it is my pleasure to testify before the Subcommittee on the question of health care in rural America. I am Dani Cossette. I am a member of the American Association of Nurse Anesthetists. I am also a private practicing nurse anesthetist in a rural area of Kansas.

The AANA represents 23,000 certified registered nurse anesthetists (CRNAS). At one time in the past decade we had over 200 educational programs and had over 1,000 graduates per year. Now the field faces a severe shortage. We have about 90 programs and are graduating less than 600 CRNAs per year. About 50 percent of all CRNAs are hospital employed; 38 percent are physician employed; and 12 percent are either what they call free-lance or self-employed.

In rural areas, most of the CRNAs are either hospital employed or self-employed. CRNAs provide 70 percent of the anesthesia administered in the rural area. For example, in Iowa there are 120 hospitals; 100 of those hospitals are serviced as far as the anesthesia services by CRNAs only. In many States—Montana, South

Dakota and Wyoming—CRNAs are about the only anesthesia provider; and at the same time, CRNAs are still providing 60 percent of the anesthesia services in the urban medical centers as well.

The recent shortage of health care workers showed that there is a shortage over 2,000 CRNAs nationally. The major barrier to CRNA services in the rural system today is the Medicare reimbursement system. This payment system discourages access to CRNA services for the rural areas. As the fees allowed are substantially less than the cost of the CRNA services for supplying her own service or his service, or for the hospital employing that CRNA.

The payment system for the CRNA and the related services is a fee schedule under Part B. It was unanimously approved and endorsed by this Committee. It was enacted as part of the budget reconciliation in 1986 and was implemented as of January 1, 1989. CRNAs do not balance bill their patients. Therefore, if the payment is too low, there is no way for the CRNA to be able to seek compensation.

HCFA has implemented a fee schedule which by our estimate is 35 percent below the cost incurred in furnishing CRNA services. This system also has state-wide variations which differ as much as 70 percent within the State and there is no apparent rationale. The system includes one fee schedule for CRNAs who are medically directed by an anesthesiologist and one fee schedule for those who work on their own without the medical direction.

There is a wide and rather unsound difference which can be detected between Idaho and Wyoming—two neighboring states where the fees for nonmedically directed services vary as much as from $10 to $19.

Mr. Chairman, we have supplied HCFA with substantial data on CRNA salaries, fringe benefits and overhead. We have supplied three membership surveys and a study of over 10,000 randomly selected surgical cases which was conducted by Touche Ross. The data clearly indicates that the cost per unit of service for a CRNA is $14 for the medically directed CRNA and $21 for the nonmedically directed. HCFA's own survey indicates that the cost per unit of service is about $11 and $21.

If the fee schedule is not increased to the amounts indicated by us of $14 and $21, respectively, hospitals will be unable to afford the CRNA services because they will lose money and many self-employed CRNAs cannot go out to the rural areas. We have had numerous letters and calls from CRNAs. In my own area, Goodland, Kansas which has always been supplied by two CRNAs—one has now left. I really doubt that the other one will stay long, being the only CRNA on call 7 days a week.

In Colby, Kansas, as of January 9th, they will not have a CRNA. Some groups of CRNAs are talking very seriously about decreasing the number of Medicare patients they do per day to one Medicare patient per CRNA per day unless they are emergencies and then trying to make up the difference with the private pay insurance.

So, I would encourage you to please look at the $14 and the $21, which would cover at least cost and overhead, and hopefully sustain the CRNA and the anesthesia in the small rural hospitals.

Thank you.

The CHAIRMAN. Thank you and I thank all of you.

I have one particular question for Dr. Bush. I am slightly annoyed at myself for not moving along faster because I have questions for each of you, and will submit questions to each of you, and Senator Durenberger may as well. But, you know, you come a long way and then you are rushed through your testimony and then you do not get to get grilled, which is fun, because you often have good discussions as a result of that. But it is part of the process and, you know, I apologize for not having longer dialogue with each of you, and I really do.

[The questions appear in the appendix.]

The CHAIRMAN. My specific question for you, Dr. Bush, is clear in its purpose and you answered a good deal anecdotely yourself. There has been some concern raised about the ability of psychologists to recognize when a patient needs appropriate medical attention. You dealt with this.

Do you think that psychologists are adequately trained to recognize when a patient needs to be referred to a medical doctor? Can you describe the assessment process that you go through when you see a patient for the first time? Are most of your patients self-referred or referred by a physician?

Dr. BUSH. Let me start first with the training. According to APA guidelines, graduate course work in psychology includes specific instruction in the diagnostic and statistical manual. Actually, the present manual is DSM-3R. And in that manual you are carefully instructed in how to differentially diagnose conditions.

In addition, I would think most competent psychologists in their intake and interview process would go through a very careful symptom checklist to ensure that they were ruling in or out possible conditions that might complicate care, especially for the elderly. What we find, in fact, is that often services are requested by physicians to make differential diagnoses, the differentiation between dimensia and depression amongst the elderly. One of the prime tools for making that differentiation is neuro-psychological assessment, to see if the course of the cognitive decline is related to a dementure process as opposed to a clinical depression.

Certainly in the case where it were determined that it was a clinical depression, then an appropriate referral could be made to a psychiatrist or other physician for anti-depressant medication. But I think that type of training is required in any APA approved clinical psychology program.

In addition, in the APA approved programs a course of physiological psychology in neuro-psychological assessment is required which introduces the psychologist to some of the basis diagnostic dilemmas that they might face. So I think one that had passed the State licensure examination process would have to be prepared to recognize those types of situations.

And again, I think that—if I had the time to provide you with several case histories, that I could demonstrate that in many cases when there has been the diagnostic dilemmas it has been the careful psychological assessment process that has been used to make that type of a diagnosis or that type of referral.

The CHAIRMAN. And there has been no hesitancy on the part of psychologists in your judgment, as a general matter, to head patients in another direction when you see that is necessary?

Dr. BUSH. Certainly not in Montana. I think—It always perplexes me to see the turf battles, if you will, that exist on a national level between psychiatry and psychology. We do not see that in Montana. We have such a positive working relationship with psychiatry and M.D.s in our community and throughout our State, and we regularly refer back and forth.

I find it baffling when I see the fighting amongst professionals that I think have some common cause in serving patients. So I am surprised when I hear concerns. Certainly, if there are ill-trained professionals, within psychology or any other profession, that do not know how to make diagnoses then they need to be properly trained or not allowed to practice within their State.

But I feel like that we have a Board of Licensure that is very strict in their testing procedure to make sure that we do not have unqualified professionals operating within out State.

The CHAIRMAN. Thank you, Dr. Bush, Pat, Ms. Cossette, Dr. Towers, David, Tom, thanks a lot. Thanks for being here.

This hearing is adjourned.

[Whereupon, the hearing was adjourned at 12:36 p.m.]

APPENDIX

ALPHABETICAL LISTING AND MATERIAL SUBMITTED

PREPARED STATEMENT OF BRUCE BEHRINGER

Mr Chairman and members of the Committee:

Thank you for the invitation to testify before this Committee studying the issue of rural health manpower. My name is Bruce Behringer. I am the Executive Director of the Virginia Primary Care Association, an organization which assists underserved communities throughout Virginia in seeking to establish systems of primary health care. Twenty-six of the twenty-seven communities with which I work are located in small towns and rural areas of under 3,000 persons.

I also have been appointed in 1989 as the Chair-person of the National Advisory Council of the National Health Service Corps Program.

I am a member of the Board of Directors of the National Rural Health Association, a multi-disciplinary association of health professionals devoted to increasing the awareness of rural health as an important concern in America. It is in this capacity which I will share some thoughts and views concerning the looming crisis facing our country's rural areas.

Like many public policy issues which you in Congress must consider, the need for renewed emphasis on prevention of the loss of availability of basic primary care services in rural America is now beginning to be understood by those who track such trends in this country. The fact of the matter is in spite of all of the sweeping efforts that Congress made in the 1970's to increase overall physician supply in this country and to redirect Federal assistance to promote medical education in primary care, many rural areas of the country will be faced with the prospect of decreasing physician and nursing manpower while the country as a whole sees a stable or slightly increasing manpower supply.

In preparing this testimony, I was advised that Congress likes to hear generalized facts about the problem at hand. Allow me to cite some findings from recent studies and articles which will describe the issue:

1. The Council on Graduate Medical Education (COGME) concluded that there is a geographic maldistribution of physicians, with too few physicians in many rural and innercity areas.
2. The Council also concluded that there is an undersupply of physicians in family medicine, general internal medicine and, if health care coverage is extended to the substantial numbers of children who now lack it, the future supply of pediatricians could rapidly become only adequate or even inadequate. As you know, these three specialties form the keystones to the primary care delivery in the rural areas.
3. Results of the three-year trends of 1987-89 for the National Resident Matching Program showed declines in preferred choices of medical students for family practice, general/internal medicine and general practice. If three years of successive declines in choices of these primary care graduate training programs is a trend, not only is the current supply of available primary care physicians questioned by COGME but also the future supply.
4. Twenty-five percent of rural physicians may retire during the next five years according to a national 1988 survey. Recent findings from a physician distribution study looking at the years 1975-1985 indicates that increases in total physician supply in small rural counties has increased only 14%, compared with larger rural counties with a 47% increase and the entire country with a 32% increase.

5. According to the Department of Health and Human Services there are a total of 1,931 primary care Health Manpower Shortage Areas (HMSAs) remaining in this country of which 73% are located in rural areas. The primary federal program targeted to address the needs of these areas has been the National Health Service Corps. As you know, Congress has eliminated funding for the scholarship component of this program which has been responsible for placing 15% of all physicians now practicing in small towns.

6. Rural Americans account for almost one quarter of the population of the country, a third of the nation's elderly and over half of the poor. Though Congress has made significant strides in increasing Medicaid eligibility options for low income pregnant women and children through the Medicaid program, still only one- fourth of the rural poor qualify for Medicaid compared with 43% of the poor in innercities. More significantly, current Medicare payment policies discourage physicians from practicing in the rural areas. A recent *Medical Economics* survey showed that even though it cost an average of $9500 per year more in rural areas to operate a medical practice, Medicare pays almost 50% more for an office visit to an urban doctor than for the same visit to a rural one.

The trends are clear: In the future, *small towns and rural areas* with a *high percentage of poor and elderly* residents that *already have too few physicians many of whom are reaching retirement age,* will be searching for new and replacement physicians from a *declining pool of primary care specialists without the assistance of the primary Federal program* which was targeted to meet their needs and *competing in a reimbursement environment which rewards the choice of urban practice* for these physicians. This is no simple problem, nor there can be a simple solution.

I would not want you to construe the statements as being critical of the efforts that Congress has made in the past and is currently considering to assist rural communities. Indeed your efforts have resulted in millions of rural residents receiving high quality medically appropriate care in their localities. However, the retrenchment of federal assistance programs linked with the demographics of rural populations and their physicians linked with the declining trend in the selection of primary care specialties by new physicians all point to an inevitable slow collapse of the progress which has been made in the past and the spector of future shortages.

To address these factors, the Federal policy response has focused upon the goal of assuring the availability of health manpower in rural and underserved areas. My comments this morning will address existing Federal efforts, how they might be combined and specific alterations and additions recommended to insure this policy goal.

The first broad policy being implemented is strategy *to promote change in the existing medical education system* in this country to enhance a possibility of selection of primary care training among medical students and practice in undeserved and rural areas by physicians completing primary care residencies.

The Federal Government currently provides for a large percentage of the cost of medical schools and graduate medical education. This is done through payments for services rendered to publicly insured patients through Medicare and Medicaid, an indirect medical education adjustment through Medicare payments to teaching hospitals and Medicare direct cost reimbursements for graduate medical education program expenses. Additionally, federal research dollars funded through the National Institutes of Health are a second key component of federal assistance. Added to these basic sources of funding have been more categorical approaches begun in the 1970's and continued through the 1980's to promote curriculum changes in medical schools to enhance primary care training. These have included funds through the Public Health Service's Bureau of Health Professions in the form of grants to establish departments of Family Medicine; provide supplemental support for Family Medicine, General Internal Medicine and Pediatrics residency programs; promote preceptorships and other experiences in primary care in underserved areas through the Area Health Education Center (AHEC) Program; and assist supportive programs for rural underprivileged medical students through the Health Careers Opportunities Program. Most recently, Congress has approved a Rural Health Medical Education Project to enhance exposure of primary care residents to rural practice.

A second strategy focuses on the individual medical student or physician. This approach has *provided incentives to increase physician supply in rural and underserved areas.* Federal programmatic efforts have been focused on three approaches. Scholarships have been provided through the National Health Service Corps and Exceptional Financial Need programs. A new approach has been the development of the National Health Service Corps and Indian Health Service Loan Repayment Programs, an attempt to attract physicians indebted with medical school loans to practice in high-need areas. A third approach currently being proposed by Senator Pryor is the Rural Primary Care Incentives Act of 1989. This method will provide tax incentives in the form of tax credits for physicians to serve in Health Manpower Shortage Areas.

The third major Federal strategy devised to impact on rural health manpower has been *to stabilize health service delivery systems and practices in rural areas.* Two methods have been used. The first is to establish and provide financial assistance to practices in high need rural areas. This is done through the Community and Migrant Health Centers Program as well as the National Health Service Corps Scholarship Private Practice Option Program. Each of these have been proven highly successful in creating practices which assure access for all regardless of the ability to pay. Over 300 not-for-profit corporations served almost three million rural and frontier residents during 1988 through the Community Health Centers Program. Many of these practices are dependent upon the employment of physicians obligated to practice in under-served areas and because of their geographic isolation and dependence upon variable rural economics, competing in the market place for unobligated physicians has proven very difficult. The second Federal approach has been to target specific reimbursement assistance for publicly insured patients to help to financially stabilize these practices. The Rural Health Clinics Act authorized cost-based reimbursement for practices in rural shortage areas which use the services of nurse practitioners or physician assistants. Another new program is the Incentive Payments for Physicians from Underserved Areas. It provides a bonus payment to primary care physicians in HMSAs who accept Medicare assignment. In the near future, Congress may also be investigating the most significant change in physician reimbursement methodology, one based upon a Relative Value Scale methodology. Increases in reimbursement for primary care services provided by primary care specialists could have a tremendous impact on the choice of primary care training among medical students and stabilization of rural practices.

Given this framework of extensive Federal involvement and the existence now and the potential increasing problem of availability of health manpower in rural areas, some long and short term recommendations are in order.

One general recommendation is to study each of the Federal investments that is currently being made and analyze its contribution toward the goal of assuring availability of health manpower in underserved and rural areas. Certainly there are other policy goals to be considered but current programs should be clearly focused toward contributing to this goal. A second general recommendation is to review the interrelationship of these investments, determining what incentives or disincentives have been legislatively or administratively enacted to promote or restrain cooperation, coordination and program linkages to assure positive and reinforcing effects toward the goal.

Some specific recommendations which would significantly impact on the existing and portending lack of health manpower in rural and underserved areas include the following:

1. Medical schools which find it within their mission should be encouraged to adopt selective admission policies to encourage those most likely to return to rural areas to enter their school. These medical schools should receive financial consideration for their involvement in this effort.
2. Congress should continue to support specific programs which enhance medical school and residency program experiences in rural areas.
3. Within the framework of research already proposed and funded by the Federal government, special consideration should be given to enhancing and supporting primary care research, thus broadening the base of financial support for those related medical school departments as well as increasing the nation's understanding of primary health care issues.
4. Reconsideration should be given to re-expanding Federal financial support for medical students and physicians through service contingent programs targeted to high need Health Manpower Shortage Areas in the country. A mix of methods, including scholarships, loan repayments and tax incentives should be broadly defined in order to meet the diverse needs of the health manpower as well as rural communities. Further, all service contingent financial assistance should be predicated on a policy goal of assured access for all through quality health care.
5. In the short-term, Medicare reimbursement policies which continue urban-rural differentials should be amended. The incentive payments for physicians in under served areas program should be expanded, increasing the percent of bonus payments and including all rural Health Manpower Shortage Areas. In the long run, the urban/rural differential payment policy should be eliminated.

6. The Rural Health Clinics Act which provides for cost-base reimbursement for Medicare and Medicaid services should be amended to promote greater participation among rural health care providers. This would include automatic certification for rural community and migrant health centers, updating the eligibility and certification process to reflect the current shortage of midlevel practitioners allowing states to designate underserved areas to meet special needs, clarifying the coverage of nurse-midwife services for clinic certification and promoting the program for greater enrollment.

7. Continue an expanded support for the development of systems of primary care accessible to all regardless of ability to pay through rural community and migrant health centers.

8. Consideration for changing physician reimbursement through the Health Care Financing Administration by adopting the Relative Value Scale methodology, thereby increasing reimbursement to primary care providers whom rural areas are so highly dependent.

In summary, the issue of availability of health manpower in rural areas is real and according to all sign posts, will intensify in the future. I have spoken only of physicians, particularly primary care physician is sues. The Committee will also hear from others representing other professions in which needs will be equally acute. Current Federal investments should be reinvigorated with program policies explicitly emphasizing coordination and congruency with the goal of assuring availability of health manpower in rural areas.

Prepared Statement of David W. Bush

On behalf of the 90,000 members of the American Psychological Association (APA), the nation's largest organization dedicated to the advancement of the science and practice of psychology, I thank the Chairman and Members of the Finance Committee for the opportunity to testify on the very critical issue of rural health care in America, and to specifically address the crisis in rural mental health care delivery. The APA applauds the Chairman and Committee Members for their commitment to improving the health care of older and disabled rural Americans through reforms of Medicare policies.

I am Dr. David Bush and I represent the American Psychological Association at this hearing today. I am a clinical psychologist practicing in the area of Great Falls, Montana. As a rural health care practitioner, I have first hand knowledge and experience of the difficulties associated with delivering and obtaining health care in rural America. I would like to share with the Committee some examples of the typical hardships older and disabled Americans experience in their efforts to obtain health care services, and to describe the need for vital services such as mental health treatment in rural populations. Finally, I would like to discuss the enormous inadequacies of the current health and mental health delivery system in underserved areas, and to offer several recommendations to improve care to our older citizens living in these areas.

I. PROBLEMS UNIQUE TO RURAL HEALTH DELIVERY

The 1980s have been a time of great financial and social hardship for all rural Americans; there have been foreclosures on family farms, a decrease in demand for domestic petroleum, losses in the lumber industry, increased international competition for the textile industry, and mine closings. With the deteriorating economic conditions have come increased personal and family stress, increased incidence of child abuse, increased alcohol abuse, greater numbers of suicide, a higher incidence of anxiety and depression, and poorer health as insurance benefits are depleted. These are circumstances which effect all members of the family, the young as well as the old.

National data suggest the elderly comprise about 12 percent of our total population, yet in many of Montana's rural counties, the elderly now make up over 20 percent of the population. In Montana, and many other rural states, there has been a significant exodus of youth from states, leaving the tax base weak in the face of increasing costs for the care of our senior citizens. With Medicare costs estimated at $93 billion the next fiscal year, and Montana facing increasing pressure to produce income for the Medicaid system, seniors are feeling the financial crunch both nationally and at home.

There is a host of problems challenging my state. Drought-stricken counties experienced further setbacks last year and had difficulties matching funds for meals on wheels, legal services and health care. Of Montana's 27 rural hospitals, 23 are in serious financial straits because of inadequate reimbursements. Specialty services such as obstetrical care is almost non- existent, outside of the larger urban centers in the state. And, distances required for travel in a state as large as Montana, coupled with a dwindling population and tax base, has created a health care crisis. Unmet service needs of the elderly are significant enough that the Department of Family Services has authorized the Division of Aging Services to conduct a survey in June and July of this year to assess the number of senior citizens who are underserved or inappropriately served. Disabled citizens of the state also go unserved in rural Montana due to the lack of available specialists. For example, a family living in Conrad, Montana, live in a state of constant stress with their two-year old son who suffers from a severe, chronic seizure disorder. They travel over 150 miles to see a pediatric neurologist, and have almost lost their son on three occasions because adequate care was not available close to home.

II. MENTAL HEALTH CARE NEEDS OF OLDER AND DISABLED RURAL AMERICANS

Research supported by the National Institute of Mental Health, the National Institute on Aging, the Veterans' Administration, the Action Committee to Implement the Mental Health Recommendations of the 1981 white House Conference on Aging, and many others, demonstrates solid evidence about the mental health of older persons and their psychological and behavioral problems, about the utilization (or non-utilization) of psychological services by the aged, and about the current nature of the unmet needs for psychological support and services among the aged.

Current estimates suggest that there are approximately 26 million persons age 65 or older in the United States (about 12-13 percent of the national population), and that their concentration in rural areas is disproportionately high. While many of these individuals are mentally and emotionally sound, it has been estimated that 10 percent to 28 percent of older Americans living in the community (2.6 to 7.3 million individuals) have mental disorders serious enough to warrant professional attention. Unfortunately, it has also been estimated that 50 to 70 percent of the elderly in need of mental health services will not receive them.[1] Recent reports from the NIMH-funded Epidemiological Catchment Area studies [2] document two trends: approximately 10 percent of older adults have a mental disorder; and cognitive impairment resulting from Alzheimer's disease or another dementia accounts for approximately half of the mental disorders of the elderly.[3] Despite these levels of impairment, older adults are under-represented in the case loads of traditional mental health settings,[4] and are over-represented in other settings, such as nursing homes.

Older persons who are in need of mental health services are a heterogeneous population, but may be grouped into three broad categories. These categories represent different etiological factors for the mental health disorders and may represent different service needs. First, individuals with a history of chronic mental impairment who have reached old age have predominant mental disorders such as schizophrenia, severe depression, severe character disorders, and chronic addictive disorders. Many of these individuals were once residents of state psychiatric hospitals, but were transferred to nursing homes and board and care facilities during the deinstitutionalization movement begun in the 1960s.

The second category includes older persons who developed mental disorders in later life, with no prior history of mental impairment. The predominant disorders in this category include anxiety disorders, major depression, social withdrawal, multiple drug use and misuse of prescription drugs, alcohol abuse, organic brain syndrome, and dementia (including Alzheimer's disease). Within this category there is concern about suicide, as men over the age of 75 have the highest rate for all age groups. Persons in this category are more likely to reside in the community and be cared for by their family, and some are residents of nursing facilities.

The third category includes individuals with mental disorders associated with physical health disorders. Examples include severe anxiety associated with gastrointestinal complications, hearing loss that may lead to delusions and social withdrawal, cardiac disease, chronic pain, and depression. The interaction between mental disorders and physical illness in the elderly is well-documented, and is a focus of continuing research.

Older persons with mental disorders differ from other age groups in that they are more likely to have multiple symptoms and complaints. The aged may have overlapping and interdependent medical, social, behavioral, and mental health problems, requiring the attention and coordination of service systems as well as service providers.

In a state like Montana, very real mental health needs of Medicare- eligible citizens are much more likely to go unmet for reasons unique to rural life, but exacerbated by inadequacies in the current Medicare system. Because of current Medicare restrictions, the majority of mental health needs of Medicare beneficiaries must be met by general practitioners who admit their lack of training and expertise in the care of emotional disturbance. Even with a referral to psychiatrists in major urban centers of the state, an elderly patient is faced with a three to six month wait for an appointment. Imagine the devastating impact of such news to one suffering from depression or unbearable anxiety. The shortage of professionals recognized by Medicare is so great, Mental Health Centers are routinely screen all patients through clinical psychologists and social workers before they are allowed to see a psychiatrist.

III. THE FAILURE OF THE PRESENT SYSTEM TO PROVIDE QUALITY MENTAL HEALTH CARE TO OLDER CITIZENS

Research and clinical experience have clearly demonstrated that older persons do respond well to appropriate psychotherapeutic, behavioral, and social interventions. Unfortunately, older persons rarely receive the mental health services they need. This is true for both the public and private mental health systems and is true for both rural and urban areas, but extreme in rural areas.

The pattern of inadequate mental health services to older persons persists as a result of a combination of factors: poor reimbursement structures under federal health programs; a reduction of federal mental health funding under the Alcohol, Drug Abuse and Mental Health Services block grant; the continued fear and stigma that still haunt our national conception of mental health disorders; and the problems inherent in delivering services in many rural areas—the great diversity in cultures and language, racial and ethnic groups, occupations, lifestyles, physical geography and isolation, and lack of professional specialists.

One feature most critical to the availability of care is geographic access to qualified health and mental health experts. Unfortunately, the current maldistribution of psychiatrists—generally the only Medicare-recognized mental health professional, compounds the problem of already limited access to services in rural areas. Many of the rural elderly simply do not have geographic proximity to a psychiatrist.

A study conducted by Applied Management Sciences (1988) documented the state/county distribution of psychiatrists and licensed clinical psychologists. This study concludes that psychiatrists are not located in two-thirds of U.S. counties. More equitably distributed psychologists, however, could fill about 40 percent of that gap in mental health care coverage.[5]

A SysteMetrics McGraw Hill (1989) distribution study corroborated the findings of the earlier survey and concluded that the maldistribution of psychiatrists is a problem which is seriously impeding access to mental health care among the elderly.[6] There are approximately 25 states in which 10 percent or more of the population live in counties that do not have a psychiatrist but do have one or more psychologists. In addition, an analysis of counties defined as urban or rural found that 75 percent of the rural elderly (1,748,816 persons) live in counties that *do not* have psychiatrists. About 30 percent of the rural elderly live in counties that have psychologists only.

It is a simple fact that poor access to a very limited pool of providers in very underserved areas—in this case, Medicare-eligible psychiatrists—contributes significantly to the elderly not receiving needed mental health services. It also contributes to the problem of inappropriate treatment or mistreatment by forcing the elderly to bring their mental health complaint to more accessible primary care physicians who generally are not trained in mental health care and either misdiagnose the problem about 50 percent of the time [7] or prescribe harmful and inappropriate drug treatment.

In Montana, presently 36 psychiatrists practice in the state and all but 5 practice in the 6 largest cities in the state, leaving 78.9 percent of the state, 62.9 percent of the rural population, and 44.1 percent of the elderly population unserved. On the other hand, 13 counties without psychiatrists have licensed psychologists who are trained to meet the emotional needs of this population. These counties contain over 120,000 individuals and over 15,000 of them are elderly. Without significant change in the Medicare system, these citizens will continue to want for access to services. Nursing homes, home health care agencies, and state aging services are asking for help, but cannot engage the services of qualified psychologists for consultation because of Medicare restrictions.

Two cases readily illustrate the problems of rural mental health. Elmer, is a 57 year old, developmentally disabled client who has resided in group homes or institutions much of his life. He presently lives in Big Sandy, Montana, in a group home, and staff have been concerned because of medications he has taken for the past 20 years. Because no specialist was available, Elmer's psychotropic medications were monitored by a general practitioner in the area. These neuroleptic drugs are often used to "control behavior," but dangerous side effects are often associated with their long term use. Unfortunately, Elmer's use was not monitored appropriately and he now suffers from Tardive Dyskenisia, an irreversible central nervous system disorder that could have been avoided.

The tragedy of the case is the failure of the system to respond to staff concerns ten years ago. No psychiatrist was available or willing to work with Elmer, and the licensed psychologist in the area was not consulted due to Medicare restrictions. Yet this psychologist was trained in less aversive behavioral techniques the staff might have used to treat Elmer's aggressive behaviors without the devastating side effects, and was equipped to work with the primary care physician regarding a more appropriate treatment program.

Beth, is a 64-year-old patient suffering from an anxiety disorder and periodic depression. During the recent record setting cold spell, she was forced to drive three hours to see a psychiatrist who saw her for 15 minutes to refill her medication. When she called my office, she was in tears, wondering why the licensed psychologist 15 minutes from her home was not eligible to see her. In her own words, "I just wanted someone to talk to who would understand my problem." The cases above are not unique to Montana, but rural states across the country have experienced similar difficulties.

III. RECOMMENDATIONS

There is substantial unmet need for mental health services among older adults, particularly for those living in rural, underserved areas. However, effective treatment approaches are available—even for those most impaired and even in the settings with the greatest need. Optimal service and treatment, however, requires a system that eases access to a variety of providers and settings, and if possible, removes as many financial disincentives as possible.

Medicare must be more responsive to the needs of the older, rural American and clear many of the barriers these Individuals face in obtaining mental health care. To address the problems we have raised, the American Psychological Association makes the following recommendations:

1. That psychologists be included for direct reimbursement for mental health services under Medicare Part B. The Medicare delivery system is an archaic, outmoded, and unduly restrictive system leading to inadequate access to mental health care, frequent misdiagnosis of mental health problems by general practitioners, and oftentimes harmful treatment of those in need of mental health care. Including psychologists for direct reimbursement will substantially eliminate the current disservice to our nation's aged.
2. That Medicare recognize more fully and specifically cover mental health services delivered by or through settings such as day-treatment programs, partial-hospitalization programs and nursing homes, and that Medicare provide coverage of services provided by mental health experts such as psychologists working or consulting with these facilities and programs.
3. That Medicare provide greater direct support or support through demonstration projects to existing rural health delivery systems (combinations of hospitals, rural health clinics, community health and mental health centers) to develop more coordinated, innovative and aggressive mental health programs in rural areas, including community education and outreach, and a network that allows access to mental health specialists.
4. That the federal government ensure that present and future geriatric mental health personnel needs are being met through clinical and research training programs supported by the Department of Health and Human Services, the National Institutes of Health and National Institute of Mental Health, the Veterans Administration, and other Departments and agencies that serve older persons. The shortage of mental health personnel trained in geriatric service is a critical national problem. Concerted efforts are needed to training both students and faculty in geriatric mental health services. Clinical training funds should be used by professional schools and departments (including medical schools) to: (a) develop a greater number of specialized courses in geriatrics, (b) expand supervised internships or residencies in geriatric mental health service delivery (particularly in rural areas), (c) expand continuing education courses in geriatric mental health care, and (d) increase the number of new faculty with expertise in aging within departments of medicine, psychiatry and psychology.

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RESPONSES BY DR. DAVID BUSH TO QUESTIONS FROM SENATOR HEINZ

Question 1. One of my concerns is that we do not have an good research base comparing the relative outcomes of patients treated for the same conditions by different types of providers. To what extent do you support, and believe such research is valuable in ensuring high quality car? How might such research be carried out and applied:

Answer 1. Your concern about having an adequate research base comparing the "relative outcomes" of patients treated for the same conditions by different types of providers" is a legitimate concern. I am very supportive of such research if it is done according to adequate research methodology. I might suggest such research be carried out by qualified third parties who would not be biased toward one particular treatment modality or provider group. For example, Dr. Carl White, at Utah State University, is an expert in research methodology and might conduct such research. Likely, the most appropriate design would be a double blind research study in which clients were randomly assigned to treatment providers and treatment outcomes were assessed by an independent researcher who did not know who provided the service.

Criteria for treatment efficacy could be clearly identified and a meta-analysis of past research could be used to determine which treatment criteria are most productive. A wealth of data already exists comparing different treatment modalities for conditions such as clinical depression. In my personal files I have over 100 research articles on depression with a preconceived conclusion a combined treatment approach using cognitive behavioral therapy and occasional pharmacological agents is preferred. However, such conclusions depend on the age of the client, together with the nature of the affective disorder.

Researchers would have to agree on common definitions of the mental health problems to be studied, as well as common definitions of the treatment modalities and treatment providers to be studied, and have a Mutually acceptable monitoring process to make sure the clients did indeed receive the treatment they were to receive.

I could continue, but for the sake of brevity let me suggest such research be carried out by independent and well trained research methodologists in concert with clinicians, and the results be applied in formulating models for rural health clinics.

Question 2. Expanding direct reimbursement to multiple providers raises several, potentially problematic issues such as the potential for (1) discontinuity in patient care, (2) unbundling (and higher costs) of care, (3) opportunities for induced (and unnecessary) referrals, and (4) exclusion of the primary care physician. How might we protect against these risks in expanding Medicare's direct payment policy?

Answer 2. In response to Question 2, the risks you mentioned for discontinuity in patient care, higher costs of care, opportunities for induced and unnecessary frills and exclusion of primary care physicians are legitimate, but I think there are realistic steps to protect against these risks in expanding Medicare's direct payment polio. First, I do not believe discontinuity in patient care occurs with other specialties, such as neurology, cardiology, or radiology. Whenever a patient is in need of a specific treatment, appropriate referral is made with adequate correspondence between treatment providers. In my present practice, I have an excellent working relationship with most of the physicians at both of the major hospitals, and our communication back and forth remains important on both sides. I believe most competent psychologists are aware of the need for communication between professionals.

In response to your second concern, please refer to the budgetary impact report by Pete Marwick & Co. You will note the estimates are realistically suggesting reductions in costs of medical care services by including such professionals as psychologists. Hence, rather than an increase of health care costs, unbundling may indeed result in cost savings to the Medicare system as senior citizens are provided with needed mental health interventions.

In response to your third concern, our State Medicaid system has dealt with the possibility of induced referrals through an overall ceiling on the amount of monies available for services to Medicaid recipients. It is then up to responsible professionals to use those funds most efficaciously. For example, in my practice I have a number of adolescents who receive individual and/or group therapy. Nevertheless, there is a ceiling on the amount of clients available for services; therefore, in concert with the adolescent, his family and other professionals, we determine a treatment plan which would be most appropriate. Sometimes this might mean using part of the monies for a psychological evaluation, in other instances using all the money for family therapy, and in some instances using the monies for individual and/or group therapy. By establishing a ceiling or cap on the amount of funds available, physicians and non-physicians alike would have to decide which health concerns need to receive greatest priority so a "blank check" mentality does not develop. Having peer review and quality assurance built in allows for accountability and suggests whenever an out-of-the-ordinary case arises, preapproval must be obtained before making costly referrals.

Finally, on item 4, "Exclusion of the primary care physician" could be eliminated by exploring the common practice in most psychological service agencies. Psychologists routinely request records from other providers, and likely, mandating such, a practice is unnecessary as it usually occurs. Abuses to appropriate clinical practice needs to be handled on a state-by-state basis by the governing boards of that profession. Hence, if there are irresponsible psychologists or other professionals, they need to be disciplined by their state associations for not following appropriate practice, including regular communication with the primary care professional involved with the case. In some instances, it may be the psychologist is the primary care provider and the physician is the source of referral who should be corresponding with the psychologist. Hence, regardless of professional affiliation, regular communication is advantageous and appropriate.

Question 3. In what categories of health manpower, other than physicians, do we have or soon face serious shortfalls in rural areas? What incentives (educational, professional, and/or financial) might be offered to reverse or avoid such shortages?

Answer 3. With regard to your third question, is apparent that not only do we face serious rutfalls in earlier areas with physicians, but also with clinical psychologists, nurses, and health care technicians. As we have surveyed psychologists around the state, we find the primary reason most of them leave the small rural communities is lack of collegial relationship and support. It is very difficult to maintain a solo practice in a small community because the therapeutic relationship sometimes prevents social relationships with members of the community. Hence, psychologists are often isolated from social activities as their clients do not include them in such activities. Further, in a state like Montana, distances between professionals prevent regular meetings. Hence, opportunities for exchange about difficult cases and receiving supervision can be difficult, if not impossible. Lack of financial reward is a problem but is usually mentioned second, third or fourth on the list of primary concerns. Hence, in addition to considering financial incentives, such as tax breaks or supplementing the cost of education, more importantly creative alternatives such as collegial exchange is needed. A realistic way to provide such collegial exchange would be to establish rural health networks in which professionals from smaller communities gather together for training, review of cases, and idea exchange. Professionals could rotate from rural community to rural community providing support for one another and also providing needed specialized care for patients in those communities. While the professional would have a home base, perhaps one week a month or one day a week they could rotate to other clinics.

I hope these few ideas have been of some value in responding to the questions you had. I appreciate your support of mental health needs in rural states such as Montana. I hope these answers have reinforced the need for inclusion of psychologists in the Medicare system to more adequately serve the needs of the elderly and to eventually reduce the costs of the Medicare program. Please feel free to call or write if you have further questions.

PREPARED STATEMENT OF DANI M. COSSETTE

Mr. Chairman: It is my pleasure to testify before the Subcommittee on the question of health care in rural America. I am Dan Cossette, representing the American Association of Nurse Anesthetists (AANA), Chair of the AANA Practice Committee and a private practicing CRNA in a rural area, Salinas, Kansas. The AANA represents 23,000 certified registered nurse anesthetists (CRNAs). CRNAs must hold a baccalaureate degree, have at least one year of acute and critical care experience, complete an approved 24 month nurse anesthesia educational program, and pass a national certification examination. At one time in the past decade there were over 200 approved training programs for CRNAs which graduated over 1,000 students per year. Now the field faces a severe shortage as we have about 90 approved programs and will graduate less than 600 students this year. CRNAs are authorized to provide all aspects of anesthesia by state laws which govern the scope of CRNA practice.

About 50% of all CRNAs are hospital employees, 38% are physician employed and 12% are self employed. The Center for Health Economics Research estimates that about 20% of the 20 million anesthetics are administered by CRNAs working alone while the remainder of CRNAs work in a joint practice arrangement with anesthesiologists. In rural areas, most CRNAs are self employed or hospital employed.

CRNAs provide about 70% of the anesthesia administered in rural areas. For example, there are about 120 hospitals in Iowa; 100 of those hospitals are in rural areas or small towns and CRNAs are the only providers of anesthesia at those hospitals. In many states, such as Montana, South Dakota, and Wyoming, CRNAs are about the only anesthesia providers. At the same time, CRNAs also provide over 60% of anesthesia in large urban medical centers as well. A recent report on the shortage of health care workers cites that there is a shortage of 2,000 CRNAs nationally. The shortage of CRNAs therefore will likely have substantial impact on access to surgical care in rural areas.

BARRIERS TO CARE IN RURAL AREAS

The major barrier to CRNA services in rural areas today is the Medicare payment system for CRNA services. That payment system discourages access to CRNA services and therefore surgical services in rural areas because the fees allowed are substantially less than the cost of practice for a CRNA or the cost of employing a CRNA. The payment system for CRNA anesthesia and related services is a fee schedule under Medicare Part B. It was unanimously endorsed by this Committee and was enacted as part of the budget legislation in 1986 and has just been implemented as of January 1, 1989. CRNAs do not balance bill patients under this legislation so, unlike physician services, if payment for CRNA serves is too low there is no way to seek compensation for the true cost of the service from the patient.

HCFA has implemented a fee schedule which is by our estimates 35% below the costs incurred in furnishing CRNA services. That system also has state variations which differ by as much as 70% and with no apparent rationale. The system includes one fee schedule for CRNA services furnished with medical direction by anesthesiologists and another for non-medically directed services. In most rural state CRNAs furnish all anesthesia services and so not practice with anesthesiologists. The wide variations and unsound basis of both fee schedules is shown by comparing, for example, Idaho and Wyoming. The fees for non-medically directed services vary from $10 to $19 between those states. Fees in both Idaho and Wyoming are less than our estimates of the cost of CRNA services.

COST OF CRNA SERVICES: $14 AND $21 A UNIT OF SERVICE

Mr. Chairman, we have supplied HCFA with substantial data on CRNA salaries, fringe benefits and practice costs. We have supplied data from three membership surveys and a study of 10,000 randomly selected surgical cases conducted for us by Touche Ross, the national accounting firm. These data clearly indicate that the cost per unit of service is approximately $14 for a hospital employed CRNA who is medically directed by an anesthesiologist and $21 for a CRNA who is elf employed or hospital employed and not medically directed by an anesthesiologist.

HCFA's own survey of 2,000 hospitals indicated a cost per unit of service of about $11 and $21 respectively. The difference between HCFA's $11 per unit cost and our $14 per unit cost for medically directed services is a function of HCFA not using current 1987 or 1988 salary data and the exclusion of overhead practice costs.

WHY IS THE HCFA FEE SCHEDULE SO LOW?

It is low because HCFA did not use updated salary and earnings data, and HCFA did not include any general cost of practice or overhead amount. 1988 salary data show a 12.8% increase in salaries from 1986 to 1988, whereas HCFA allowed only 6%. HCFA cost report data, our data from self employed CRNAs, our Touche Ross study and the Harvard RBRVS data all indicate that a general cost of practice figure of 20% of salary is very reasonable but HCFA allowed only 7% of salary for billing costs.

WHAT PROBLEMS DOES THE HCFA FEE SCHEDULE CAUSE?

If this fee schedule is not increased the amounts indicated by us as the cost of a unit of service, $14 and $21 respectively, hospitals will not be able to afford to utilize CRNAs because they will lose too much money, and many self employed CRNAs will not be able to afford to practice in states with average or lower fees, thereby limiting care. We have had numerous letters and calls from CRNAs in rural areas indicating that they cannot sustain their practice under the fee schedule proposed. Our 1988 membership survey indicated that self employed CRNAs have been paid an average of $21 a unit of service by Medicare in 1988 under hospital contracts, yet the HCFA fee schedule ranges from $11 to $19 per unit and averages $14 for CRNAs working alone. In one state we have had a specific request from the Medicaid agency and the Indian Health Service (IHS) as to whether they could pay more than the Medicare fee schedule in order to assure CRNA services on an Indian reservation. This is likely not a unique situation, yet Medicaid and the MS cannot pay more than the Medicare rate. More important, there will be little incentive for nursing students to enter the field of anesthesia. If the fee schedule remains as proposed CRNA educational programs will be forced to close. In the long run, there will be a seriously diminished supply of CRNAs to furnish care and that will hurt rural areas the most, since they rely almost wholly on CRNAs for anesthesia services and the health care costs per patient may in fact be higher overall.

LOW VOLUME ISSUES AND RURAL AREAS

Fee schedules, like DRG payments, are applicable on a per case basis. They are based on averages; average costs and average numbers of cases. Rural areas tend to have a lower volume of cases per provider than other areas and often suffer under such systems. In 1988, we worked with the Congress to establish an exemption from the CRNA fee schedule for low volume hospitals in rural areas. That exception is for hospitals with 250 or fewer surgical cases per year. The exception was necessary because Congress, at HCFA's request, included a technical provision limiting payments to CRNAs to the physician prevailing charge for anesthesia in the state. This provision hurts rural areas because physicians generally do not practice anesthesia in rural areas with below average volume of cases and the physician prevailing charge may not be sufficient in the low volume areas. Also, physicians may balance bill beneficiaries so even with the lowest prevailing charges, physicians charge beneficiaries about $25 to $30 per unit. While the rural exception may need some slight expansion, the answer for rural health care and CRNA services is generally to increase the fee schedule to the levels we recommend of $14 and $21 a unit of service. At those fees, most CRNA providers will be able to sustain a practice.

CONCLUSION

Mr. Chairman, we urge you and your colleagues to include legislation in the FY 1990 Budget Reconciliation legislation establishing a national fee schedule at $14 per unit of service for medically directed CRNAs and $21 a unit for non-medically directed CRNAs. These rates represent a fair estimate of the cost of CRNA services. Payments under these two fee schedules could not exceed the statewide prevailing charges of participating physicians under our proposal unless no physician anesthesia services were available in the particular geographic areas in a state in which the CRNA service was furnished. As under current law, the services would be subject to mandatory assignment.

The adoption of this proposal will assist in assuring adequate access to health care in rural areas and provide beneficiary protection since CRNAs take assignment on all claims.

PREPARED STATEMENT OF PAUL G. FITZPATRICK

Good morning, Senators. My name is Paul Fitzpatrick and I am here today representing the New York State Department of Health and the New York State Rural Health Council. We appreciate the opportunity to present testimony on rural health care, a priority interest on the part of New York.

It may surprise many to discover that New York is a rural state. More than three million people live In rural areas of New York, almost as many people as in the entire state of Connecticut. New York's rural residents outnumber the total populations of twenty-five other states, including among them Maine, Rhode Island, Delaware and West Virginia. Forty-four out of New York's sixty-two counties are defined as rural, with Population densities generally falling below 150 persons per square mile. Major contributions to New York's economy come from such rural-based industries as forestry, dairying, wine and grape production, tourism and general agriculture.

The circumstances that rural areas face—such as scattered resources, small population bases, long distances to be travel led—are known to create obstacles to rural development. To contrast some of the differences between New York's rural and urban areas, our rural residents have lower incomes, and our rural communities have more residents below the poverty level and more elderly living in poverty. With less favorable demographics, rural communities have fewer potential wage-earners to support dependent children and the elderly. Educational levels attained by our rural residents are also lower. Our rural residents face health concerns that include higher death rates from motor vehicle accidents and other accidents. Deaths from suicide are also more common than in urban areas. Teen pregnancies and low birthweight babies are other major health problems. The resources available in our rural areas to deal with these problems and circumstances are limited, especially in contrast to what is available in more populated areas. Rural areas of New York State have fewer primary care physicians and physician specialists per population. They also have fewer dentists, pharmacists and social workers. While New York is facing health personnel shortages statewide, recruiting health personnel is more difficult in rural areas. because of lower salary levels of rural providers and because the supporting systems rural providers rely upon are not as strong or as well-developed as in urban areas.

New York has a long standing commitment to providing opportunities for all its residents to lead healthy, productive lives. In response to the growing health care problems of rural areas in 1991, a statewide Task Force on Rural Health Strategies was created to assess and develop strategies for responding to rural health care delivery problems. The Task Force concluded that several concerns required priority attention: access to health care; lack of health care services and personnel in many rural areas; and, the need to reorganize systems to maximize existing resources. The report of the Task Force on Rural Health Strategies now provides a framework for responding to rural health issues in the State. In 1988, Governor Cuomo appointed a statewide Rural Health Council and it has continued the work of the Task Force by implementing the strategies and recommendations contained in the Task Force Report.

There are two related and overriding issues which rural areas of New York State confront. First, there is growing concern about the viability of the existing rural health delivery structures. Second, and highly related, is the shortage of health personnel, particularly providers of primary care services.

VIABILITY OF RURAL DELIVERY SYSTEMS

In terms of historical development rural hospitals have traditionally served critical, often central, roles in maintaining viable health care delivery systems. The structure of the delivery system became highly dependent, overly so in many cases, on the presence of the hospital. More recently rural hospitals have been grappling with issues of economic instability, case payment systems, new medical technologies, inadequate supplies of health personnel, shifting consumer expectations and a host of other issues. The decline of the rural hospital has forced a re-examination of the organizational structures for health care delivery. It appears essential that if rural health care delivery systems are to remain viable, a significant restructuring must occur. The independent and fragmented structure which currently exists' must be reorganized to provide for a far greater integration of services which is not so highly dependent on the presence of the hospital. This is not to say rural areas should be without hospitals but that the organizational focus of delivery systems should be on the most needed services. In most communities these are primary health care and emergency medical care.

Restructuring of rural health care delivery systems in New York has been supported through' several initiatives. Initiatives have been pursued to support rural hospitals in transitions to more needed services, the development of rural health networks, the development oF primary care services, and the enhancement of emergency medical services. I will describe each of these four initiatives in more detail.

Rural Hospitals In Transition

First, the loss of acute care services, a reality for several rural communities in New York and a potential for many other communities, demands immediate action. New York's *Rural Health Care Services Diversification Program* and *Rural Health Care Development Program* responds to this demand. When a determination has been made that a hospital should substantially modify its mission, resources are made available to enable the hospital to implement changes by helping meet the costs of architectural design, legal work and capital development. Unfortunately the resources made available have only scratched the surface of the need.

Rural Health Networks

In communities which suffer the loss of hospital services or which do not have services, a major challenge is to guarantee that a viable health care delivery system is sustained. To assure that quality health services are accessible and delivered efficiently New York Is exploring new organizational structures to link together independent service providers. The formation of "Rural Health Networks" is an initiative which we feel holds significant promise for rural communities.

The rural health network is an evolving concept which is defined as a locally based and governed organization which has the capability of providing either directly or indirectly, a minimum set of health and health related services including primary, acute. emergency, home, and dental care, health education and promotion, transportation and other services which are specifically identified as needed by a community. In addition to service delivery, networks' functions can include administration, coordination, training, recruitment, planning, program development, capital development, fund raising, and quality assurance. No specific organizational structure has been identified for networks, however at a minimum, it requires formal linkages among participating health and human services providers. The structure of networks needs to be responsive to circumstances and local conditions of each rural community's delivery system. The expected benefits to be realized by forming a rural health network include greater economies of scale by pooling personnel and financial resources, thus lowering the unit cost of service delivery. Similarly, a network can pool expertise for purposes of quality assurance, administration, planning and capital development. Networks will also enable providers to increase their market share, improve access to a wider range of patient services, and enhance the recruitment and retention of needed health personnel.

New York has created a Rural Health Network Demonstration Program to support this restructuring option and is currently funding thirteen network sites. After only a year and a half, successes have already been realized through the demonstration program. They include: significant improvements in the coordination of service delivery: the designing and introduction of new programs and services: and the increased availability of health and other support personnel. The demonstration program has also surfaced some barriers to restructuring and network development, in particular. They include: overcoming existing institutional, often parochial, interests: reluctance to create new organizational structures which force realignment of existing provider relationships; lack of staff expertise to accomplish the complex tasks of planning, negotiating and brokering which can lead to a formal network structure. Perhaps the most significant barrier to network development has been the uncertainty about long term funding. It will be essential to identify a permanent funding stream for networks if they are to succeed. New York is currently examining several funding options to support rural health networks, including: the use of existing reimbursement streams such as Medicaid, Medicare, and Blue Cross; local government support: business and industry support; and state level support through a system of grants.

Primary Care Services Development

A third restructuring initiative has been to support the development of primary care services. New York has made a major commitment to expanding primary care services through its Primary Care Initiative. Since 1985, this grant program has provided $5 million annually for primary health care provided through freestanding clinics, community health centers, and hospitals. The program resulted from a reorganization and integration of grant programs supporting the continuation and the expansion of primary care for medically underserved areas and populations. In addition to funding projects that expand primary care services in high need areas, the program also provides funding and management support to financially distressed health clinics that operate in underserved areas. A substantial proportion of the $5 million goes to projects in rural areas.

Emergency Medical Services Enhancement

Restructuring in New York has also focused on supporting the enhancement of rural emergency systems. Changes in the delivery system, particularly the loss of hospital acute care, heighten the need for effective emergency medical response. Emergency communications and medical response systems are critical components of an effective system. Reorganization of New York's emergency services has focused on the development of a comprehensive statewide communication system and on support to the predominantly volunteer-based rural emergency squad. New York is evaluating the feasibility of establishing a statewide 9-1-1 system, as has already been done in eight other states including Delaware. Maine and Minnesota. Recent state legislation encourages the expansion of local tax districts as a means of providing more reliable financial support to volunteer ambulance squads. Steps have also been taken to upgrade emergency personnel skills, in part through the infusion of additional funds for training.

HEALTH PERSONNEL SHORTAGES

The second major issue, and one which some argue is the most critical, is the shortage of health personnel. Health personnel shortages are not, as I'm sure you know, unique to rural areas. However, because of the decided disadvantage of rural areas in recruiting and retaining health personnel, the shortages are even more threatening. The shortage of primary care physicians in particular is reaching crisis proportions. Medical schools are not training sufficient numbers of primary care physicians to respond to the growing need. In fact, graduates in primary care specialties have been declining. This, in the face of the retirement of large numbers of rural primary care physicians, spells impending disaster.

The health personnel shortages are further exacerbated by the unintended, yet real reimbursement differentials between urban and rural providers. Like it or not, our Medicaid and Medicare reimbursement policies make it all but impossible for even the most committed individuals to locate in rural areas. Those policies also provide very little incentive for medical students to choose primary care specialty areas. We must take a long hard look at a medical education system which is failing to respond to the needs of our communities. The criteria for selecting medical students, the curriculums of medical schools, and the sites for providing clinical training must place greater emphasis on societal needs.

Several steps are being taken in New York to address the problem of shortages of primary care physicians, nurses, mid-level practitioners, home health care personnel, and emergency medical technicians. A Labor-Health Industry Task Force on Health Personnel issued a comprehensive report in January of this year which has recommended a number of initiatives directed at both the government and health care sectors. Initiatives have been undertaken that will improve working conditions and compensation for shortage occupations, support career ladders and career mobility, and increase the number of new entrants into the health professions. New York has also continued its efforts in placing physicians and allied health professionals in high need areas.

Increased Compensation

Compensation for health personnel has been increased through reimbursement rate adjustments. Earlier this year, Governor Cuomo ordered health facility reimbursement rates for hospitals, nursing homes, home health agencies and diagnostic and treatment centers adjusted upward to reflect higher labor costs. For both 1988 and 1989 this will mean in additional $193 million.

Improved Working Conditions

To improve working condition, New York's Governor has requested state funds to cover the state's share of rate adjustments for day care for children of patient care workers and for career advancement training. Health facilities across the state are providing improved working conditions and benefits—particularly for workers in shortage occupations. There appears to have been a significant expansion in such benefits as day care services, flexible hours, and progressive educational leave policies, particularly for nurses.

Career Ladders

In support of better career ladders and career mobility, 10 model projects are training over 300 entry level workers for skilled shortage occupations. With additional support from other sources, such as health worker unions and foundations, several hundred additional workers should be in training programs by the end of 1989. Key elements include:

—paid educational release time and part time work;
—educational flexibility;
—increased educational support;
—expanded use of competency based testing;
—service commitment:
—new cooperation between health and educational facilities.

Increase Supply of Health Personnel

An important initiative to encourage entry into shortage professions is the establishment of health career oriented high schools. The Departments of Health and Education are establishing 12 programs around the state to prepare high school students to enter post-secondary schools of allied health and nursing. The program includes: a revised and enriched curriculum in math, science, and health careers; a linkage with a college with programs in allied health and nursing; and mentorships and structured work experiences in health facilities. Numerous hospitals around the state are also considering "adopt a high school" type programs.

Physician and Allied Health Professions Placement

New York has also used loan forgiveness programs, practitioner placement programs and site development funds to encourage primary care physicians to locate in underserved areas of the state. In the past three years, 90 physicians have been placed in rural areas through these various programs.

The State Health Service Corps provides scholarships of up to $15,000 per year for up to two years in a variety of health professions, in return for service obligations. Within the past three years, over 50 nurses, physician assistants, physical and occupational therapists, speech therapists, dental hygienists and pharmacists have been place in rural facilities through this program. The State Health Service Corps was expanded in 1988 to include midwives as an eligible occupation. Placements sites were expanded to include community health centers.

It should come as no surprise to those at the federal level that significant financial assistance will be needed to support the changes that rural areas need. The federal Rural Health Care Transition Program initiated in the past year to assist rural hospitals with transitions to other needed services is a beginning'. However if rural hospitals are to serve a meaningful role within the future rural health care delivery system they will require substantial resources beyond those that individual states can provide. Funding streams must be identified to allow further diversification of rural hospital services, and to create health networks with organizational permanence to serve these communities. The emergency care system, always a critical component, will become even more important as additional communities lose their hospital acute care capacity. Increased federal support for rural emergency communication systems and training will be needed to accomplish enhanced systems.

It is essential, as we continue to respond to national health needs, that we fully recognize rural interests. It may be necessary to evaluate pending health legislation to assure sufficient allocation of resources to rural areas. It may also be necessary to examine existing programs to insure that they provide adequate support to rural areas.

New York recommends a renewed federal commitment to the training of primary care providers on all levels. Federal influence must be brought to bear on our medical education system to bring about a major transformation in our manner of choosing and educating students. We must select more of those interested in rural practice, and we must prepare students for rural practice. It will also require a major shift in our reimbursement policies such that providers of primary care have sufficient incentives to choose primary care practice and to locate in underserved areas.

Finally, and in closing, we support an expanded federal Interest in conducting research on rural health issues. As we pursue solutions to our rural health problems it is essential that we base our strategies on sound—research rather than anecdotal or ad hoc study. The Federal Rural Health Research Center Program of the Office of Rural Health Policy is key to responding to rural health issues. New York supports the Program and stands ready to assist in conducting research which can eke a difference in finding answers to the complex problems of rural health care.

RESPONSES OF PAUL G. FITZPATRICK TO QUESTIONS FROM SENATOR HEINZ

Question. When alternative delivery systems have been introduced in rural areas—to replace or augment the local hospital—how have communities responded? Is there the same confidence in alternative systems or do you see patients driving further distances to get traditional, hospital-based care?

Response. The impact of the development of alternative delivery systems in rural areas—to replace or augment the local hospital—has not been specifically measured. New York state has experienced varying degrees of success or failure as new delivery systems evolve. Success is most highly dependent on the local circumstances which must be confronted. In communities with significant levels of resistance to change the ability to maintain the same confidence in a an alternative systems has been very difficult. However, in communities which have recognized the need to change and which have participated in a planning process to redesign health care delivery there has been considerable success in maintaining confidence levels. Simply stated, when communities, and their leaders recognized the need to change the transition to alternative systems is far more successful. Our experiences in communities where change is suggested from outside, either by state or regional level health planning groups and where there is little community support, the transition is far more difficult.

Assuming many "alternative" systems replace hospital based acute care we suspect patients are traveling greater distances for hospital based care. Given the early stages of development of many alternative systems, empirical studies have not been completed which can document the changing travel patterns. It has been our experience that even in rural communities with hospital based care there is a significant amount of travel to the nearest urban hospitals for care. Whether this reflects a lack in confidence in local services or a need for more sophisticated services is not clear.

Question. The bottom line in any community-based approach is the outcome for patient care. What outcome or trend data do we have to show that the quality, level, or outcome of patient care has changed after "alternative" systems to hospital-based care are introduced?

Response. Outcome or trend data comparing hospital based care with community based "alternative" systems is woefully lacking. The state of the art of quality assurance programs has been largely limited to assessment of institutional care and often limited to input rather than output measures. New York has initiated a quality assurance system for hospital care which uses outcome measures. This system however has not been extended to "alternative" (non hospital based) systems. New York's Rural Health Network Demonstration Program initiative has identified quality assurance as one of the functions of rural health networks. Establishing quality assurance programs which extend beyond institutional settings is a important activity which must be pursued as community based "alternative" delivery systems are developed.

Question. One of my concerns is that we do not have a good research base comparing the relative outcomes of patients treated for the same conditions by different types of providers. To what extent do you support, and believe such research be carried out and applied?

Response. It is essential that research be conducted which compares the relative outcomes of patients treated for similar conditions by different types of providers. New York State is interested in conducting such research and has submitted a letter of interest to the DHHS's Office of Rural Health Policy concerning establishing a federally designated Rural Health Research Center. This Federal program offers a significant opportunity to conduct research on rural health issues in a coordinated and comprehensive fashion.

Question. In what categories of health manpower, other than physicians, do we have or soon face serious short falls in rural areas? What incentives (educational, professional, and/or financial) might be offered to reverse or avoid such shortages?

Response. Shortages of health personnel currently exist in categories such as: registered nursing (including nurse practitioners); physical, occupational and respiratory therapy; radiography; laboratory technology; physician assisting and home care, among others. While these shortages are occurring statewide, rural areas are experiencing problems particular to rural service delivery.

Characteristics of personnel shortages in rural areas include: variation in the type of shortage by geographic area; vacancy rates that are lower than those reported In urban areas but greater difficulty in filling vacant positions when they do occur; problems with access to support services such as day care and transportation to work; and, in many areas, lower salaries and fringe benefits than those in urban/

suburban areas. Many of the well-documented problems in rural service delivery impact on personnel shortages, including lack of professional supports and referral networks, patient volume that may not support a full-time health professional, particularly in services such as the therapies, and patient access problems including transportation and ability to pay.

Information on vacancy rates and recruitment seems to indicate a positive relationship between recruitment/retention of health professionals and proximity to, and affiliations with, health occupations education programs. Health care labor markets appear to be very local, particularly for nursing and many allied health professions. Expansion of education programs in proximity to rural areas can help to increase supplies of trained workers in proximity to rural areas can help to increase supplies of trained workers in local markets, particularly when combined with effective health careers marketing. Innovation in education programming is also need. Cross-training in fields such as nursing and therapy can make more effective use of limited manpower. Cross-training also has potential in entry level occupations such as home health aide, allowing for a skill base that can be applied in both institutional and home care settings.

Financial support through scholarships can also increase the supply of workers in rural areas. Scholarships with subsequent service obligations can provide resources to potential workers while assuring that the workers will return to the facility/area of greatest need. Models of this type include scholarships provided on a statewide basis, by individual counties or by individual facilities. In many cases this support can provide an opportunity for upgrading to existing entry level employees, enhancing retention by providing career ladders in health.

New York State is in the process of implementing the recommendations of the Labor-Health Industry Task Force on Health Personnel. Initiatives underway include increased scholarship support, coordination of local health care and education communities, increased reimbursement for salaries and benefits, support for training and upgrading of existing workers, and work with the education system to focus on health careers and availability of health occupations education. These initiatives must be combined with efforts to enhance rural service delivery in order to provide the structure necessary for effective utilization of health professionals in rural areas.

Prepared Statement of Tom Harward

Mr. Chairman, on behalf of the American Academy of Physician Assistants and the 20,000 physician assistants we represent, I want to thank you for this opportunity to present our views.

As you indicated, my name is Tom Harward, and I an a physician assistant from Belington, WV. In addition to my duties as a full-time clinically practicing PA, I am also the Administrator of the Belington Clinic, a federally certified rural health clinic. Finally, I have the privilege of serving as the physician assistant member of the West Virginia Board of Medicine. As you may recall Senator, you first appointed me to this position in 1982 when you were Governor.

For the past 11 years, I have been the principal health care provider for Belington and the surrounding communities in Barbour County. Over the past several years, we have seen many physicians come and go but we have always maintained the clinic and continue to serve the needs of this rural community.

Mr. Chairman, I need to state at the outset that my personal rural health experience is limited to Belington in particular and West Virginia, in general. I point this out because in talking with my colleagues in other States and regions, I find that we in West Virginia are somewhat unique. We have a medical practice act that does not discourage the utilization of PAs in rural practices such as mine. And, we have a State agency that understands the Rural Health Clinics Act.

The academy has prepared a chart showing the number of federally Certified Rural Health Clinics (RHCs), the number of counties eligible for an RHC, and the total number of counties in each State that have health manpower shortage areas whether they are rural or not. I would ask that this chart be inserted in the record.

As you can see, West Virginia has done quite well in terms of getting clinics certified. But as successful as we have been, it is clear that more needs to be done.

As you examine this chart, you see that there are some states, most notably Texas, Nebraska, Michigan, North Dakota, our neighbor Virginia, Indiana, Arkansas, Louisiana, and Maryland that have only one or no rural health clinics. This, despite sizable portions of their State that are deemed RHC eligible. While the absence of any rural health clinics in some of these States might be attributable to individual State laws which discourage the utilization of PAs in satellite clinics, much of the shortfall can be attributed to a poor State understanding of the Rural Health Clinics Act.

It is for this reason that the academy believes that one of the most important improvements you are recommending in the Rural Health Clinics Act is the requirement that the Office of Rural Health provide both general and technical information to entities seeking certification as a rural health clinic.

Over the past 10 years, the academy has received numerous inquiries from individual PAs, as well as potential employers, about the particulars of the Rural Health Clinics Act. And while we have been able to provide these questioners with general information about the program, we often find it necessary to refer these individuals to the State agency charged with administering the program, only to find that the agency knows little, if anything, about the rural Health Clinics Act.

Information has been equally lacking at the Federal level. Two years ago, when the academy staff was encouraging members of the House and Senate rural health caucus to look at the Rural Health Clinics Act, it was almost impossible to find anyone in the Federal bureaucracy who knew anything about the program. And unfortunately, those individuals who were familiar with the program only understood their particular area. Consequently, there was no one who understood the policy implications of the Rural Health Clinics Act or how it might be used more effectively in the fight to improve access to health care in rural America.

This point cannot be overlooked, Mr. Chairman. Until the Rural Health Clinics Act is fully incorporated into the overall Medicare-Medicaid philosophy, it will continue to function as the "unwanted step-child" of the Medicare and Medicaid bureaucracy. We all know too well what happens to unwanted step-children: they get abandoned or, worse, abused.

The academy applauds your initiative in this area and we believe it, more than any other change you might recommend, will have a positive effect on the image and growth of the Rural Health Clinics act.

On the other proposed changes included in the Rural Health Clinics Improvements Act of 1989, our comments are equally positive. As you know, staff from the academy has worked closely with your office in trying to develop changes that will improve the Rural Health Clinics Act. Many of the changes you are recommending come directly from practicing physician assistants and their clinic administrators.

Those most significant to the PA community involve the staffing requirements.

First, we strongly support a reduction in the RHC staffing requirement from 60 percent to 50 percent. While to some this may seem like a minor change, for many it is rather significant.

At the present time, several physician assistants are attempting to staff two rural health clinics in different communities. Under present guidelines, these individuals must put in extra long days in order for the clinic to maintain its RHC status. By lowering the staffing requirement from 60 percent to 50 percent, you will allow these dedicated individuals to work more normal hours and still serve both communities. We believe this reduction will also encourage other PAs to consider such an arrangement in the future.

Second, we support the PA/NP waiver proposed in your bill.

Frankly, we wish this were not necessary but the fact of the matter is that there is a tremendous shortage of physician assistants and nurse practitioners and we simply are not able to keep up with demand. Because of this shortage, a number of long-standing rural health clinics have been closed or threatened with closure because of their inability to find a physician assistant or nurse practitioner. the academy's position is that if a clinic can find some alternative means of keeping its doors open and the absence of a PA is the stumbling block, then some type of reasonable flexibility must be made available to ensure that a community does not lose all health care because they cannot find a PA or NP.

We do believe, however, that the clinic must demonstrate that it has made a good faith effort to find and employ a PA or NP and further, that this waiver only be temporary. In addition, we believe the clinic must make a continuing effort to find such staff.

We are supporting this waiver because several RHC clinic administrators, particularly those co-located in community health centers, have indicated that this will help them keep their doors open. Frankly, Mr. Chairman, we question whether this will "solve" the problem. But in the interest of trying to work with our friends in the CHC community, we have agreed to support this provision.

The academy would recommend, however, that this waiver program be closely monitored and Congress come back and review the success or failure of the change in a few years. We hay find it necessary to make some mid-course corrections if this waiver proposal does not work out as planned.

In addition to enactment of the Rural Health Clinic Improvement Act of 1989, we would also strongly request that the committee enact S. 461, legislation introduced by Senator Grassley authorizing Medicare coverage for physician assistant services in all currently uncovered practice settings.

You have personally supported and cosponsored this legislation in the past, Mr. Chairman, as have a significant number of the members of this committee. At various times, C.B.O. has indicated that there would be no cost or very little cost to the Medicare program as a result of covering the physician services provided by physician assistants.

The importance of S. 461 and its house counterpart, H.R. 1175, is evidenced by the chart I introduced earlier. As you can see, Mr. Chairman, in addition to the large number of rural communities eligible for a rural health clinics, there are nearly 600 counties which are either totally or partially designated health manpower shortage areas but that cannot benefit from the rural health clinic program because they are not defined as "rural" counties.

However, many of the communities presently designated as "urban" are in fact very rural. The problem is that the present method of determining the difference between "urban" and "rural" puts many communities in the wrong category.

One such community, Mr. Chairman, is Cedar Springs, MI, population 2,000. A colleague of mine, Mr. Charles De Vreugd, has been working as a physician assistant in Cedar Springs for the past 12 years. In many respects Chuck is my counterpart. We are approximately the same age, graduated from a PA program at roughly the same time and both chose to practice in rural medically underserved communities.

In addition, the medical practice acts of Michigan and West Virginia both encourage the utilization of PAs and in particular, the utilization of PAs in satellite clinics.

For the purposes of our discussion, Mr. Chairman, by satellite clinic I mean a situation where the supervising physician is on-site for only a portion of the time. in other words, the PA is practicing in a site remote from his or her supervising physician.

The difference is that for the past 12 years, I have had the benefit of the Rural Health Clinics Act and Chuck and the Cedar Springs clinic have not. Despite the unavailability of rural health clinic status, Medicare has been covering Chuck's services.

That is, I should say, until about 6 months ago when the Cedar Springs clinic received a notice from its Medicare carrier that payment for PA services would no longer be made because the carrier suddenly realized that the supervising physician was not on site full time.

Understand, Mr. Chairman, that the clinic had informed the carrier that the physician' was only on site 1 day per week and the clinic clearly identified on its claims forms that the services were provided by a physician assistant in accordance with Michigan State laws.

The truly sad part is that in addition to stopping any additional payments, the carrier has requested over $50,000 in back payments for what it believes were inappropriate charges for physician assistant services. Not surprisingly, the very existence of the clinic is threatened.

Much like Belington, the community of Cedar Springs pooled its resources several years ago, purchased an abandoned building and turned it into a fine medical facility. In Belington, the abandoned building was the old school, in Cedar Springs, it was a pool hall.

For 12 years, residents of Cedar Springs and the surrounding communities have received around the clock 7 days per week health care from a fine physician assistant. Now, all of that may be lost. And why? Because of a narrow interpretation of the Medicare law—a law which must be changed to reflect the way modern medicine is practiced and the way physician assistants are utilized.

It is ridiculous, Mr. Chairman, to require that the physician be "in the building" at the time a PA performs his or her services, if such a requirement is not mandated by the State's Medical Practice Act. It minimizes the effectiveness of the PA and it prohibits many communities from having access to quality health care.

For some, this is a cost issue. To them, when Medicare patients in communities like Cedar Springs or Belington don't have access to health care, the Medicare program saves money. I would suggest, Mr. Chairman, that just the opposite is true. If the Cedar Springs clinic is forced to close, it will end up costing the Medicare program money.

There's an old saying, "you can pay me now or you can pay me later." Well, that's just what happens in Medicine. If Medicare beneficiaries do not have access to basic primary care medicine, they will avoid the short-term costs of regular blood pressure checks, they won't seek help for that nagging chest pain or the migraine headaches.

But sooner or later, the high blood pressure that causes the headaches or the coronary occlusion that's the root cause of the chest pain will be discovered and a problem that could have been handled by a change in diet or routine medication will now require major surgery to repair.

So the carrier may force the closure of the Cedar Springs clinic and it may even see a short-term drop in Medicare costs, but eventually, it will be made up in triplicate. And all at the expense of one more rural community that will have to go without.

Ask yourself this question, Mr. Chairman, why should Cedar Springs be any different than Belington? Why should the Medicare beneficiaries of cedar springs be penalized for having the terrible luck to live in a community that the Federal Government considers urban!

The fact is, there is no justification. You cannot rationalize the discrepancy. We must change the law that allows this type of situation to continue.

Senator Grassley's bill and its companion measure in the House, sponsored by Congressman Wyden, would rectify the situation and ensure that all Medicare beneficiaries have equal access to physician assistant services. Furthermore, it accomplishes this goal in a manner that attempts to ensure that every time a Medicare beneficiary is seen by a PA in lieu of a physician, the program has a chance to save some money.

This committee has seen fit to cover PA services provided in hospitals, nursing homes, rural health manpower shortage areas and for assisting at surgery. The time has come to cover the physician services provided by PAs in all remaining practice settings. To do any less would be a disservice to millions of Americans who stand to benefit from the high quality health care provided by our Nation's physician assistants.

As a final point, Mr. Chairman, I think we would be remiss if we did not take this opportunity to comment briefly on the work of the physician payment review commission.

As you know, the commission has come out with some rather sweeping recommendations on changing the way Medicare calculates payments for physician services under Part B. As with most changes in life, there will be winners and losers.

Indeed, if you want to know who are the winners, see who is supporting the change to a resource based relative value scale. If you want to know who are the losers, see who is opposing the RBRVS.

The academy, for its part, has been supportive of the RBRVS concept because it will place greater emphasis on resource input and attempt to have reimbursement more reflective of the amount of "work" involved. In this way, family physicians and internists will receive greater recognition of their cognitive skills.

We are concerned, however, that the commission still has not taken into consideration the amount of work actually being performed by non-physician providers, such as PAs, in the care of Medicare patients. Such an oversight will unnecessarily lead to a payment mechanism that does not truly reflect the current state of affairs in medical practice.

You should not develop a system of reimbursement that completely ignores the valuable contributions of physician assistants, nurse practitioners, and a whole range of other non-physician providers.

We strongly encourage this committee, as it deliberates on the implementation of the commission's recommendations, not overlook PAs and others but instead, fully incorporate them into the new system.

One final point, Mr. Chairman. Although manpower issues are not within the jurisdiction of the Finance Committee, I would encourage you to use your position as chairman of the Medicare Subcommittee to alert your colleagues on the labor and human resources committee, which does have jurisdiction over health manpower legislation, to the seriousness of the PA/NP shortage issue.

Not unlike many of my colleagues, I was not particularly young when I graduated from the George Washington University Physician Assistant program in 1976 at the age of 35. As I see 50 closing in, I begin to think about how much longer I will want to remain active in clinical medicine. More importantly, I wonder who will come along to take my place in Belington when I decide to hang up my stethoscope.

Certainly there are many more opportunities for a young PA today than there were when I graduated 13 years ago. Whereas PAs were once found almost exclusively in rural and urban medically underserved communities, today they can be found in virtually every area of medicine—from the artificial heart transplant team in Kentucky to the staff of N.I.H. doing top-flight aids research.

And while PAs, more than any other health professional, still show a commitment to rural health—over 15% in rural communities of under 10,000, we cannot ignore the fact that the numbers are gradually declining. This committee, and the entire congress, must appreciate and realize that adequate financing alone is not the ultimate solution to rural health care.

Your interest in addressing the serious problems in rural America is greatly appreciated by those of us who are charged with providing health care. Your willingness to speak out on this important issue and work for reasonable solutions means a great deal, not only to the practitioners, but also to the patients we serve.

The academy looks forward to working with you and your staff over the next few months to see that the needs of rural America are not ignored.

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS

Rural Health Clinics

State	No. RHCs[1]	No. Rural HMSA Counties[2]	Total No. HMSA Counties[3]
Alabama	5	26	50
Alaska	16	9	12
Arizona	8	9	11
Arkansas	0	36	48
California	47	15	37
Colorado	12	18	31
Connecticut	0	0	6
Delaware	0	1	2
Florida	13	18	59
Georgia	22	52	76
Hawaii	0	0	1
Idaho	7	27	29
Illinois	1	23	34
Indiana	0	22	33
Iowa	10	36	37
Kansas	2	17	18
Kentucky	8	43	46
Louisiana	0	31	49
Maine	25	10	15
Maryland	0	5	12
Massachusetts	0	1	8
Michigan	0	37	47
Minnesota	3	30	35
Mississippi	9	41	48
Missouri	0	44	58
Montana[4]	0	31	30
Nebraska	0	32	37
Nevada	6	9	14
New Hampshire	2	2	6
New Jersey	0	0	8
New Mexico	23	22	26
New York	25	24	49
North Carolina	36	33	50
North Dakota	0	37	35
Ohio	16	23	47
Oklahoma	0	13	21
Oregon	8	18	31
Pennsylvania	24	28	48
Rhode Island	3	0	5
South Carolina	2	31	33
South Dakota	21	49	47
Tennessee	24	43	59
Texas	0	82	85
Utah	8	15	17
Vermont	5	8	10

AMERICAN ACADEMY OF PHYSICIAN ASSISTANTS—Continued

Rural Health Clinics

State	No. RHCs[1]	No. Rural HMSA Counties[2]	Total No. HMSA Counties[3]
Virginia	0	29	47
Washington	12	14	27
West Virginia	29	34	46
Wisconsin	4	36	45
Wyoming	1	12	13
Total	438	1176	1633

[1] 1/03/87 Listing of Federally Certified Rural Health Clinics (HCFA)

[2] 10/31/88 List of Designated HMSAs in Non-Metropolitan Areas (PHS)

[3] 9/17/87 Listing of HMs (Federal Register)

[4] The federal government last published the listing of HMSAs on 9/17/87; however, additions to that list have occurred since 1987. This accounts for the discrepancy.

AAPA RESPONSES TO QUESTIONS POSED BY SENATOR HEINZ

Question 1. One of my concerns is that we do not have a good research base comparing the relative outcomes of patients treated for the same conditions by different types of providers. To what extent do you support, and believe such research is valuable in ensuring high quality care? How might such research be carried out and applied?

Answer 1. Since the creation of the physician assistant profession over 20 years ago, the question of quality of care has been a major issue. For this reason, we suspect there have been more comparative analyses between the quality of care provided by Las and that of physicians than any other health care provider groups.

In December of 1986, the Office of Technology Assessment released its report entitled, "Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis." This study reviewed all of the available data on the three professions and made some rather dramatic conclusions. Of particular significance to you are the conclusions drawn in Chapter 2, Quality of Care.

Although the report notes that current methods of evaluating the quality of care are inexact, OTA found that, "Within the limits of their expertise, OTA provide care that is equivalent in quality to the care provided by physicians."

In addition, OTA points out that comparing relative outcomes, as you suggest, is only one measure of quality and may not provide policy makers with a true picture of the OTA impact on the quality of health care.

I should also mention that a soon-to-be released analysis of the Massachusetts Nursing Home Connection Program also supports OTA's conclusions on quality. The Connection Program is a HCFA demonstration project utilizing PAs and NPs—teamed with physicians—in the care of nursing home residents in the state of Massachusetts.

At the present time, the program operates in 28 of the state's ICF and SNF facilities. The evaluation of the study was conducted by the RAND Corporation, the University of Minnesota School of Public Health and the Boston University School of Public Health.

The analysis concludes that, "quality of care in the program was equivalent to or exceeded the quality of care provided by physicians" and goes on to state that, "several tracer illness studies showed that the quality of care provided by nurse practitioners and physician assistants in the program showed a statistically significant improvement over the care provided by physicians to the controls."

You are certainly correct in your assessment that this information is important and valuable in ensuring high quality care. It would be our position that much of the research has already been conducted with respect to physician assistants. More importantly, the research shows quite convincingly that PAs provide high quality health care that is equivalent to that provided by physicians.

Question 2. Expanding direct reimbursement to multiple providers raises several, potentially problematic issues such as the potential for (1) discontinuity in patient care, (2) unbundling (and higher costs) of care, (3) opportunities for induced (and unnecessary) referrals, and (4) exclusion of the primary care physician. Row might we protect against these risks in expanding Medicare's direct payment policy?

Answer. Role delineation studies conducted by the AAPA have concluded that PAs provide primary care services such as history taking, physical examinations, etc., no matter their practice setting. Their training and practice patterns tend to increase continuity of patient care, including patient education in health promotion and disease prevention. Physician/PA teams also facilitate appropriate referrals.

In regard to your concern about unbundling, physician assistants, unlike other non-physician providers, are dependent practitioners and always work under the supervision of a physician. Consistent with the history of the profession, we are not seeking "direct" reimbursement or "direct" payment. In addition, we only seek coverage for those services the PA provides that would have been covered by Medicare Part B had they been provided personally by a physician.

The legislation introduced by Senator Grassley, S. 461, reimburses the *employer* of the PA for the PA's services and requires that the physician assistant perform the services under the supervision of a physician. The Grassley bill defers to the state agency responsible for regulating the PA profession for the definition of supervision.

By reimbursing for PA services in the manner prescribed by the Grassley bill, the problems you have identified are avoided. It should be pointed out, however, that such a system for reimbursement only works for the PA profession because of its unique status as a dependent profession.

Question 3. In what categories of health manpower, other than physicians, do we have or soon face serious shortfalls in rural areas? what incentives (educational, professional, and/or financial) might be offered to reverse or avoid such shortages?

Answer. The Academy will confine its remarks on rural health manpower shortages to the physician assistant profession.

The shortage of PAs in rural areas is real and growing. A national survey of PA programs conducted during 1988 concluded that there were in excess of 7.5 jobs available per graduate, with many of the vacancies in rural communities.

We have also received numerous reports of Rural Health Clinics being threatened with closure due to their inability to attract a PA or NP into the practice. Older PAs are retiring or moving to more urbanized areas and clinics are finding it increasingly difficult to find younger PAs to take their place.

Despite the declining numbers of PAs in rural communities, it should be noted that PAs, more than any other health care provider, have exhibited a special commitment to providing health care to rural populations. According to the OTA report referenced earlier, "Whereas about 27 percent of the general population and 14 percent of the nation's physicians are located outside Standard Metropolitan Statistical Areas (SMSAs), 32 percent of PAs practice outside SMSAs.

We believe that part of the reason PAs have dispersed so successfully to rural communities is in part due to the heavy emphasis placed on rural medicine as part of the educational process. PA students are encouraged to do clinical rotations in rural communities and several PA programs have undertaken the training of PAs for rural practice as their special mission.

Finally, we believe the success is also a reflection of the type of student recruited into PA programs. In selecting students, PA programs place considerable weight on the willingness of the applicant to practice in a medically under- served community.

Despite the past success of federal support for PA education at getting PAs deployed to rural medically underserved areas, more is needed. Federal support for PA education has not increased in many years and this has resulted in programs having to cut back on some of the rural clinical rotations they offer. In addition, the inability to use funds to subsidize certain aspects of providing rural rotations (i.e. housing) inhibits the ability of some students to take advantage of these rotations.

Furthermore, many of the scholarship and loan repayment programs presently authorized have limited funds available and tend to restrict loans and scholarships to physicians and nurses. We believe there are many deserving PA students who would gladly work in a rural medically underserved area in exchange for a scholarship or loan.

Lastly, reimbursement disincentives that tend to discriminate against rural providers must be eliminated. While much has been done in the past two years to improve reimbursement for rural practitioners, many inequities continue to exist. A recent article in *The Internist* shows quite clearly the extent of the disparity when, for example, we find that a limited office visit in Nebraska has an approved charge of $11.64 while the same visit has an approved charge of $37.78 in New York. This type of inequity must be corrected.

PREPARED STATEMENT OF SENATOR JOHN HEINZ

Mr. Chairman, I commend you on holding these hearings, and there is a certain irony in their necessity.

In the last 50 years technological advances such as rural electrification which allowed for telephones, radios, and later TV, educational advances from one room schoolhouses to consolidated school districts, and a comprehensive highway system have all brought *rural* America out of isolation and closer to *mainstream* America.

Yet, despite improved quality of life, still lingering in these rural areas are serious problems of access to health care.

I think it's worth noting, for the record, that rural areas have traditionally been less desirable places for physicians to practice medicine. Given reduced earning potential professional isolation, lack of advanced medical technology and limited choice of opportunities for physicians' families in the areas of employment and education.

Compounding the problem of luring physicians to rural areas are the more recent phenomena of hospital closings because of low occupancy, a decrease in incentive scholarship programs which encourage physicians to go to rural areas, and a large number of retiring rural doctors.

As a result, alternative providers, such as physician assistants and midwives, have been called upon to play an increasingly critical role to help meet rural America's unique health care challenges.

We have not been totally behind the curve. The Congress has supported alternative caregivers through the funding for training programs and expanding the range of services to be covered under Federal programs. These incentives, not surprisingly, have resulted in an increase in the number of alternative providers reimbursed under the Medicare program.

However, we all recognize that there are problems, particularly in how we pay for, finance, and provide adequate access to rural health care. In large part, it seems to me that the underlying question is one of definition; when and in what settings can care be offered by alternative providers. The issue before us today is a particularly sensitive, but a necessary one for this Committee to address. I am therefore especially solicitous, Mr. Chairman, of the views and recommendations of our witnesses today.

PREPARED STATEMENT OF PATRICIA MCGILL

Mr. Chairman, I am Patricia McCill, M.S.N., R.N. I am a cardiovascular clinical nurse specialist, and the Director of Nursing at the Charleston Area Medical Center in Charleston, West Virginia. I would like to thank you on behalf of the 200,000 members of the American Nurses' Association (ANA) and its 53 constituent state nurses associations for this opportunity to address rural health care issues. I am also pleased to appear today on behalf of the approximately 40,000 registered professional operating room nurses who are members of the Association of Operating Room Nurses (AORN). We find consideration of rural health issues especially timely in light of the severe nursing shortage currently facing our country and its impact on access to health care in rural areas.

RURAL HEALTH MANPOWER SHORTAGES

More than 25 percent of all Americans live in rural areas, and yet rural America has only 18 percent of the nation's nurses. The 25-member Nursing Commission established by the Secretary of the Department of Health and Human Services (HHS Nursing Commission) to examine the registered nurse (RN) shortage issued its report in December, 1988. One of its conclusions was that the evidence of shortages in hospitals, which employ two-thirds of all RNs, is clearly a concern. RN vacancy rates have more than doubled between 1983 and 1987 (from 4.4 percent to 11.3 percent). Hospitals of all sizes, in both urban and rural areas, have been hit by the current shortage, and are experiencing difficulty recruiting and retaining RNs.

A shortage of physicians and other health care providers also exists in rural areas. However, there are four categories of nurses in advanced practice that have played a crucial role in extending physician services in rural areas, where routine access to physician services has not always been available. Nurses in advanced practice include nurse practitioners (NPs), certified nurse midwives (CNMs), clinical nurse specialists (CNSs), and certified registered nurse anesthetists (CRNAs). NPs, CNMs, and CNSs are essential providers of primary and obstetrical care. CRNAs deliver the bulk of anesthesia services in rural hospitals where the services of anesthesiologists are often unavailable. Historically, all of these nurses in advanced practice have been willing to locate in rural and underserved areas to a far greater extent than physicians. According to 1988 West Virginia Board of Examiners' statistics, West Virginia has licensed 70 NPs, 3 CNMs, 40 CNSs, and 201 CRNAs.

As the 1986 Office of Technology Assessment (OTA) report, *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis* noted, these professionals have also expanded access to care for minority populations which were underserved despite acceptable physician- to-population ratios. For example, NPs expand access for children in school settings and the elderly in nursing homes; CNMs provide maternity care for underserved, low-income women and adolescents; a study has shown that early discharge of very-low-birthweight infants, with follow-up care in the home by a CNS, is safe and cost-effective; and CRNAs provide 70 percent of anesthesia care in rural areas.

OTHER PROBLEMS UNIQUE TO RURAL AREAS

In addition to problems recruiting and retaining nurses and other health care providers, there are other problems in rural areas. Since 1984, 159 rural community hospitals have been forced to close. Of the remaining 2,700 rural hospitals, as many as 600 face closure. In West Virginia, six rural hospitals closed in just the past year and a half. A January, 1989 study conducted by the West Virginia Hospital Association cited rural location as the number one reason for the inability to recruit nurses. The HHS Nursing Commission has estimated that nine percent of rural hospitals were forced to close beds as a direct result of the nurse shortage. There are also problems with the proximity of clinics or hospitals, and the availability of adequate resources for referral purposes. Transportation problems become intensified and complicated by poverty and the lack of emergency services. Diagnostic aids such as x-ray and laboratory services are frequently absent or minimal.

Many rural residents face the financial burden of their health care alone because they are self-employed and do not have employee health insurance. According to the West Virginia Medically Indigent Health Care Services Project, in 1986, 15.9 percent of the West Virginia population had no insurance, and 132,000 working adults and their families had no insurance. Even when rural residents do have access to health care services, there often are problems of getting them to come in for care before their symptoms are severe. Consequently, rural patients are often at an advanced stage of illness when they present themselves for treatment.

FEDERAL RURAL HEALTH INITIATIVES

In recent years, there have been numerous federal rural initiatives intended to address these problems. I would like to briefly discuss these initiatives, and make specific recommendations about them.

Community and Migrant Health Centers

The Community and Migrant Health Center Act was reauthorized by the 100th Congress to support the 357 rural Community Health Centers (CHCs) and 117 Migrant Health Centers (MHCs). These centers are an important source of primary care for three million rural residents. Federal grants are used to enable the centers to offer discounted fees for the poor and near-poor, more than half the current users. But Federal funding has not kept pace with inflation. In recent years, CHCs have experienced a dramatic increase in the number of uninsured rural patients that they are treating. In addition, in the 1980's the migrant program has addressed the needs of less than 20 percent of its target population. Since 1981, rural America has experienced a 50 percent decrease in Federal funding for mental health activities. In addition, increasing community mental health services to rural areas is given a low priority ranking (62 out of 63) by State mental health directors.

Recommendations

—Federal funding for MHCs and CHCs needs to be increased to keep pace with inflation, and to reflect the dramatic increases in the number of patients utilizing CHCs, as well as the fact that 80 percent of the target population of MHCs is not being served.

—Federal funding should be allocated for the support of rural CHCs willing to offer mental health services.

Rural Health Clinics

The 1976 Rural Health Clinic Service Act expanded Medicare and Medicaid reimbursement to certified Rural Health Clinics (RHCs) to include the services of NPs and physician assistants (PAs). A NP or PA must be employed at least 60 percent of the time the RHC is operated for patient care, in order for the RHC to qualify for reimbursement. Some clinics, however, are unable to obtain or retain the services of a NP or PA. There is also a lack of publicity and information about the RHC program, and administrative delays and burdensome reporting systems make it difficult to establish a RHC.

Recommendations

—Decrease the percentage of time that a NP or PA must be employed by a RHC from 60 percent to 50 percent of the time the facility is operated for patient care, in order for the RHC to qualify for reimbursement.
—Recognize CNMs, in addition to NPs and PAs, as a type of practitioner that a RHC may employ and receive reimbursement for their services.
—Provide incentives to the States to assist in the development of additional RHC participation.
—Revise and streamline the criteria for SHC designation, and provide automatic RHC certification to community and migrant health centers operating in rural shortage areas.

National Health Service Corps

Last year, for the first time since 1982, Congress appropriated a specific $3 million set-aside for nurses in the National Health Service Corps (NHSC). While ANA had advocated that scholarships be awarded to nurses, Congress adopted a loan repayment option. The loan repayment option has a service payback requirement which was intended to result in more nurses serving in settings such as health manpower shortage areas, and community, migrant, and Indian Health Service health centers. However, in spite of promotion of the new loan repayment program by organized nursing, the NHSC has received only thirty one applications from nurses to participate in the program. Of that number, 17 applications have been accepted by NHSC, with $33,000 obligated for one nurse. Three of the 31 applications received were referred to the Indian Health Service for processing. One of the reasons for the low number of nurse applications is that some private health facilities already offer to repay nursing educational loans in exchange for service by the individual in their facilities. Anecdotal information indicates that nurses are more inclined to utilize the private facilities' loan repayment options because they provide service in more attractive settings and at a higher rate of compensation.

Recommendations

—Increase Federal funding for RNs under the NHSC program, but using scholarships instead of the current loan repayment program.
—The Secretary of HHS should be given the authority to designate specific nursing manpower shortage areas, in addition to health manpower shortage areas.
—Federal tax incentives should be available to eliminate the tax liability on NHSC loan repayments that nurses receive.

Emergency Medical Services

A 1986 General Accounting Office study found that while the "911 system" expedites quick public access to Emergency Medical Services (EMS), more than 50 percent of the nation, primarily in rural areas, is still not covered. In addition, advanced life support ambulance services were found primarily only in urban areas. It is estimated that trauma costs exceed $130 billion annually in terms of lost wages, medical expenses, and insurance administration.

Recommendations

—There should be increased coordination and services between trauma facilities.
—Federal funding should be available for the emergency air transportation of rural patients to the closest hospital.

Infant Mortality Initiatives

About one-third of all births occur in rural areas; however, rural pregnant women are somewhat less likely to have prenatal care in the first trimester. Many obstetricians, as well as family/general practitioners have discontinued providing obstetrical services because of the high cost of malpractice coverage. In 1987, a National Governors' Association survey of State Medicaid and Maternal and Child Health (MCH) agencies found that access to MCH services in rural areas was a problem in 35 of 50 states, compared to only three states where this was reported to be a problem in suburban and urban areas.

The United States ranks 19th in the world in saving the lives of babies. Rural areas have an average infant mortality rate of IS deaths per 1,000 live births, compared with the average U.S. rate of 11.2 deaths. In 1986, West Virginia had an infant mortality rate of 10.2 deaths per 1,000 live births, and ranked in the middle in a comparison of the States. Seven percent of the babies born in West Virginia have a low birthweight versus the 6.8 percent national percentage. Over 17 percent of all babies in West Virginia are born to mothers under 20 years of age. Almost 30 percent of women do not receive prenatal care in the first trimester. In 1987, although 40,000 individuals needed access to the Women, Infants, and Children program, there was only sufficient funding to accommodate 30,000. Clearly, one key to reducing infant mortality is reducing the incidence of low birthweight babies. The lifetime costs of caring for a low birthweight infant can reach $400,000. The costs of prenatal care, that might prevent the low birthweight condition in the first place, can be as little as $400.

Mr. Chairman, I had the privilege in March of introducing you to several NPs, CNSs, and CNMs in West Virginia. You saw firsthand the problems that are encountered in the provision of women and children's health care in Charleston. The West Virginia Department of Human Services found that in 1987, 47 of 55 counties did not have enough medical care for the population. The West Virginia Human Resources Association data shows that in 1986-87, one in two babies was born into poverty; one in six was born to a teenage mother; one in three did not see a physician or dentist due to an inability to pay for health care. There is an extraordinary amount of uncompensated care provided in Charleston, due in part to the fact that there are no obstetrical services in the southern part of West Virginia. About 150 women per day come to my clinic for obstetrical services. There is currently a six week waiting period at the clinic for prenatal services.

The good news is that there are several Federal initiatives that attempt to deal with these MCH crises. The infant mortality initiative provides funds for case management and care coordination services to high-risk, low-income pregnant women through the community and migrant health centers. In addition, the MCH block grant provides services ranging from prenatal care to medical care for high-risk newborns and children suffering from handicapping conditions. The immunization program provides funding for a vaccine stockpile, research, and technical assistance.

ANA and AORN believe that incentives are needed to ensure that rural residents have access to nurses, especially nurses in advanced practice who can provide services when physicians are unavailable. The 1988 report of The National Commission to Prevent Infant Mortality noted, "The number of providers willing to serve high-risk pregnant women and infants must be increased and the malpractice crisis must be addressed. The Commission encourages the development of demonstration projects to test innovative ways to increase the participation of obstetricians, family physicians, pediatricians and certified nurse midwives."

Recommendations

—Federal funding for the infant mortality initiative should be increased, as it currently reaches only one-third of the community health centers; funding for the MCH block grant and immunization programs should not be decreased.

—There needs to be a change in the Medicaid poverty level to increase access to MCH programs.

Nurse Education Act

Last year, Congress appropriated $56 million for Nurse Education Act (NEA) programs. It also reauthorized the NEA for three years and, in response to the nursing shortage crisis, significantly increased the authorization levels for programs to $102.9 million for Fiscal Year 1990 (FY 90). Several of the new NEA provisions specifically deal with rural health. First, one of the purposes under the $16 million nursing special projects provision is to increase the supply of adequately trained nursing personnel to meet the health needs of rural areas, and to provide nursing education courses to rural areas through telecommunications via satellite. Second, there is a $5 million authorization for nursing educational loan repayments for individuals who agree to serve in an Indian Health Service, Native Hawaiian, migrant, or community health center; a public hospital; a nursing facility; a rural health clinic; or a health facility determined by the Secretary of HHS to have a critical shortage of nurses. Third, there is a $900,000 rural hospital seaside to improve health services in certain qualified hospitals. Fourth, there is an authorization of $17 million for NP/CNM training, and $1.8 million for CRNA training.

Recommendations

—Fund the NEA in FY 90 at the $102.9 million authorization level.

—Authorize telecommunication demonstration projects for hospitals for use in continuing education of nurses.

—Compile a comprehensive, national data base on rural nurses; States which have agencies on rural health should be urged to collect data regarding nursing personnel.

—There should be support for nursing education programs that would provide student nurses with rural clinical placements, possibly via preceptorships.

—Research on rural nursing issues, including nurse shortages and rural practice models, should be expanded.

—Fund the $5 million authorization under the Health Omnibus Extension Act of 1988 for interdisciplinary training projects to train health care practitioners to serve in rural areas.

PROPOSED INITIATIVES REGARDING RURAL NURSE EARNINGS

We believe that two related issues need to be addressed related to rural nurse earnings: the salary disparity and salary compression between urban and rural nurses, and the lack of Federal reimbursement for rural nursing services provided by nurses in advanced practice. Exact data sources are lacking, but compensation surveys demonstrate an approximately $3,000/year salary discrepancy between nurses employed in hospitals of less than 99 beds (characteristic of rural hospitals) and nurses employed in larger hospitals. The average maximum salaries for nurses in advanced practice, as reported in the January issue of the *American Journal of Nursing* are: NPs—$36,000; CNSs—$49,000; and CRNAs— $42,000. A 1987 survey found the average CNM salary to be approximately $32,000. These salaries are much less than the average physician salary.

While 32 States now allow reimbursement for health care services provided by some level of registered nurse, the Federal sector has been a more restrictive reimbursement environment for nurses. The four Federal payers that reimburse for health care services are Medicare, Medicaid, the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and the Federal Employees Health Benefit (FEHB) program. These payers do not across-the-board mandate the direct reimbursement of nurses in advanced practice (NPs, CNMs, CRNAs, and CNSs) for providing those services for which the programs reimburse other practitioners. Currently, Medicare Part B mandates direct reimbursement for the services of CNMs and CRNAs; Medicaid mandates direct reimbursement for the services of CNMs (coverage of the other categories of nurses in advanced practice are at the discretion of each state); CHAMPUS mandates direct reimbursement for the services of NPs, CNMs, and psychiatric CNSs; and FEHB allows individual insurance plans the discretion of directly reimbursing for nursing services. In addition, for the most part, the four Federal payers do not cover health promotion and disease prevention services or case management services in health care settings in rural areas.

The 1986 OTA study that addressed NPs and CNMs concluded that, "Federal third-party payers could be more in step with new and evolving payment practices by liberalizing coverage and payment restrictions" for the services of NPs and CNMs. The study also found that in addition to improving access to care in rural areas, the weight of the evidence indicates that, within their areas of competence, NPs and CNMs "provide care whose quality is equivalent to that care provided by physicians."

Recommendations

—The four Federal payers should, at minimum, mandate the direct reimbursement of nurses in advanced practice for providing those services for which the programs reimburse other practitioners.

—The four Federal payers should also reimburse any health care provider who is licensed to provide health promotion and disease prevention services, and case management in health care settings in rural areas.

—Efforts should be made to ease the difficulties that nurses in advanced practice experience in obtaining provider numbers for purposes of securing reimbursement.

Thank you for the opportunity to present our views on rural health issues.

RESPONSES OF PATRICIA MCGILL TO QUESTIONS FROM SENATOR HEINZ

Question 1. One of my concerns is that we do not have an good research base comparing the relative outcomes of patients treated for the same conditions by different types of providers. To what extent do you support, and believe such research is valuable in ensuring high quality care? How might such research be carried out and applied?

Answer. There is a growing awareness of the need for clearer definitions of the outcomes of all categories of health care interventions. Nurses and other providers of health care are more effectively describing accountability to the consumer by planning care on the basis of achieving selected patient outcomes. There appears to be growing consumer and payor demand to link the payment for health care more directly to the outcomes attributable to that care. Both the Health Care Financing Administration effectiveness initiative and the Joint Commission on Accreditation of Healthcare Organization Agenda for Change relate to this drive to clarify outcomes of health care.

To some extent, health care provision (formerly called "treatment of disease") has been couched within a structure and process focus. The current critical attitude toward health care has turned toward looking at outcomes of care as a more appropriate focus for design of programs which evaluate care. A reasonable deduction within this focus is to look first to the desirable outcomes, and then look retrospectively to see what interventions most clearly are associated with the desired outcome. Further analysis would look to see which health provider has enough preparation to be safe and effective, and can realistically provide the interventions.

Once more clearly defined, then, outcomes of care can be matched to the interventions which most likely lead to achieving the desired outcomes. Then assignment of providing the intervention can be made to the category of health personnel whose skill and knowledge base provide the best fit to deliver the interventions. When fully played out, the scenario becomes one of determining substitutability of one category of health provider by another. 'That substitutability can be done is best illustrated by the many years of study of nurse practitioners. In one summary of fifteen studies, it was concluded that NPs are capably performing (note the present tense) 75% to 80% of adult primary-care services and up to 9O% of pediatric primary care activities. (Record, 1979).

The best example of substitutability for traditionally physician provided services has been the Office of Technology Assessment report on Nurse Practitioners, Physician Assistants, Certified Nurse-Midwives: A Policy Analysis (1986). 'The report looked at evidence for quality of care given by these providers, issues of productivity, costs and employment and how these providers improved access to care. The weight of evidence indicated in this report that, within their areas of competence, NPs, PAs, and CMMs provide care whose quality is equivalent to that of care provided by physicians. 'The report indicated that NPs and CNMs are more adept than physicians at providing services that depend on communication with patients and preventive actions.

The issue of quality of health care is best answered, to date, by comparing the quality of care of other providers (NPs and PAs, for example) to that provided by physicians. Summarizing the findings of the numerous studies of physician-extender performance in a variety of practice settings, the Congressional Budget Office concluded that physician extenders have performed as well as physicians themselves with respect to patient outcomes, proper diagnoses, management of "indicator" medical conditions, frequency of hospitalization, manner of drug prescription, documentation of medical findings and patient satisfaction. (Health Policy Program, 1981).

Another measure of quality of care provided by physician substitutes is reflected in malpractice or other legal difficulties. Only 3 of 486 employers of NPs reported any malpractice problems and malpractice insurance rates remain unchanged for more than 97% of NP employers. (Sultz, 1983). Similarly, there is no evidence that employment of PAs has increased physicians' malpractice problems. (Sargent, 1987).

Nursing's research base (Bader, 1988) indicates that current tools used to measure patient satisfaction are not specific enough to determine the relationship of multiple dimensions of nursing care with patient satisfaction. Critical commentary from the field of quality assurance indicates that the nature of the interpersonal exchange between the patient and practitioner is not clearly understood, how its attributes are quantified and how it contributes to the patient's health (Donabedian, 1988). Other research (Lalonde, 1988) has measured home health care outcomes in relation to the visits provided. 'The outcomes selected related mostly to medical care criteria: taking medications as prescribed, functional status and discharge status, although some quality of life indicators were assessed: caregiver strain and symptom distress, for example. Other published research has reached the point where meta-analysis is possible, at least for the volume of studies which relate to outcome standards in home health nursing. (Rinke, 1988).

Other than for NPs and PAs, there is less evidence at hand which relates to "treatment" (that is, providing interventions which are associated with subsequent desirable patient outcomes) provided by different types of providers. We welcome studies of the practice of clinical nurse specialists, for example in terms of achieving certain outcomes. We anticipate that the same quality of care findings will result as for NPs and PAs, both of which groups have been studied extensively. We likewise believe that the current limitations of how health care is conceptualized and operationalized do not provide the arena to demonstrate, nor the tools to measure the effects (patient outcomes) of the full utilization of clinical nurse specialists with various cohorts of client populations in terms of health promotion, disease prevention, patient education, effective parenting and other, less "medical treatment" interventions performed so ably by highly prepared registered nurses. We look for continued funding of nursing research which has already stated in the published nursing research priorities (ANA, 1985) the following related research areas: developing instruments to measure nursing outcomes; design and evaluate alternative models . . . .so that nurses will be able to balance high quality and cost-effectiveness in meeting the nursing needs of people. (ANA, 1985).

Question 2. Expanding direct reimbursement to multiple providers raises several, potentially problematic issues such as the potential for (1) discontinuity in patient care, (2) unbundling (and higher costs) of care, (3) opportunities for induced (and unnecessary) referrals, and (4) exclusion of the primary care physician. How might we protect against these risks in expanding Medicare's direct payment policy?

Answer. This question expresses concerns about the effects of extending direct reimbursement to "multiple providers." The concerns are: (1) discontinuity of care; (2) unbundling and higher cost of services; (3) induced and unnecessary referrals; and (4) exclusion of the primary physician. How might these risks be protected against?

The concerns raised are theoretically possible but practically unlikely to occur, particularly in rural health settings. First, direct reimbursement for nursing personnel in rural settings would *promote*, not harm, continuity of care because physicians are often unavailable. Nurses as case managers would also attend specifically to the continuity of care issue, whereas physicians often do not.

Second, "unbundling" services need not lead to higher costs. Payments can be reduced to the agencies to which the services were formerly attached by amounts equal to those provided to directly-reimbursed providers. Mechanisms such as expenditure limits can be designed to ensure this result.

Third, appropriateness reviews can prevent any potential problems with induced or unnecessary referrals. In reality, however, direct reimbursement for nurses in rural settings should facilitate more appropriate referrals, eliminating some more expensive physician visits which can be handled instead by RNs.

Fourth, both patients and physicians will work to maintain doctor/patient relationships. Direct reimbursement of nurses will not exclude the primary physicians.

Question 3. In what categories of health manpower, other than physicians, do we have or soon face serious shortfalls in rural areas? What incentives (educational, professional, and/or financial) might be offered to reverse or avoid such shortages?

Answer. Many studies over the years have addressed issues of supply and, to a lesser extent, issues of demand for health professionals in rural areas. Nurses in rural areas have been less studied until recently, spurred by the national nursing shortage. A number of recent efforts provide some information on the nursing shortage and some data on the shortfall of other health providers. More data is needed.

A U.S. Senate Special Committee on Aging (1988) report late last year addressed issues of supply of several health professionals in rural health care. The study echoed the 1986 OTA report which noted that nurse practitioners have expanded patients access to primary health care, particularly for minority populations. Over the years, the percentage of nurse practitioners employed in rural areas has declined, though in rural as well as in inner city areas, the client populations of nurse practitioners are mostly poor and underserved. An extensive survey in 1987 of the 12 state north central region indicated that in many practice settings, NPs (and PAs) are performing 70-90% of the functions of primary physicians at much less cost, with quite good quality of care and patient acceptance. Within that study, estimates of the population underserved by primary care *physicians* range from 2 to 12%. It is notable that the proportion of approximately 16,000 employed nurses practitioners and PAs working in health manpower shortage areas exceeds the proportion of physicians in shortage areas.

The Sixth Report to the President and Congress on the Status of Health Personnel in the U.S. utilizes a projections model to predict the nation's needs for nurses. For nurse practitioners, the expert panel believed that nurses with practitioners skills are needed in hospital and nursing home settings, a departure from the traditional practitioner role in primary health care. Further, they projected that in the year 2000, 50% of master's prepared nurses in hospital outpatient services should have practitioner skills. Nurse practitioners are recently achieving more employment opportunities within the acute hospital setting, perhaps as a result of the trends the expert panel identified. To the extent that the Sixth Report's projections are achieved, then, a significant shortage will exist for nurse practitioners. It seems reasonable to assert that the shortage will unduly affect rural areas. There are about 2,000 certified nurse midwives also employed in the nation. Regulatory and reimbursement changes have moved, albeit slowly, to facilitate the practice of nurse midwifery. Nonetheless, a frequent requirement of nurse midwifery practice acts or reimbursement policy is the availability of physician backup services. Within rural settings, the liability crisis among physicians has resulted in severe access problems to obstetric physician services. Obstetric physicians are therefore not only not available for direct care, but are not available for providing backup care for certified nurse midwives. Though employment opportunities are available for CNMs, the shortage is not acute for the above reasons, in addition to continuing restrictive practice acts on the part of some states.

For nurse practitioners and for certified nurse midwives, it should be noted that if the restrictive practice barriers of reimbursement and regulation were removed in all states, CNMs would realize their tremendous potential to meet rural birthing needs. Similarly, nurse practitioners would realize the tremendous potential to meet rural primary care and institutional long term care needs. If those regulatory and reimbursement changes came about, then a significant shortage of NPs and CNMs would be present. Particularly given the small number of nurse midwifery education programs and their limited output per year, the shortage would probably be more acute for CNMs.

Certified registered nurse anesthetists provide 70% of anesthesia care needs in rural areas. The role of CRNAs is well established and respected, even by those who ardently oppose physician substitution. Though undersupply is less acute for CRNAs that for other groups, a concern is the effect of a nursing shortage on the potential pool of nurses who apply for nurse anesthesia preparation. Given the proliferation of ambulatory surgery settings, budgeted vacancies for CRNAs may well increase, given the added intensity of CRNA staffing required by the different sites where anesthesia may be required, even within the same hospital campus.

A very recent Institute of Medicine report on allied health personnel reported four areas of current and potential shortage: physical therapy, occupational therapy, radiologic technology and medical records services. As with nurses, certain similarities seem to relate to these shortages: a predominantly female work force which has to compete with many other occupational fields who are likewise vying for qualified female applicants; starting salaries are beginning to improve, but long term (career) salary compression is a factor in retention of these professionals, and multiple factors contribute to the increased intensity of requirements for these professionals. For example, the increased need for sophisticated data manipulation to meet reimbursement and quality assurance activities is dramatically increasing the requirements for medical records professionals.

Survey results released earlier this year by the National Association of Community Health Centers and National Rural Health Association paint a bleak economic picture for the nation's rural community health centers. Findings from 284 rural community health centers reported that the failing rural economy is having a definite and adverse impact on ability to provide health services. Losses continue for these centers since, among other reasons, more and more users flock to them, and 83% of new clients are those without assets who need subsidy. Increasingly even the established center patients are less able to pay for their care. A consequent event has been to reduce personnel expenses, which in turn makes it difficult to attract and retain providers.

A rural Health Services Research Agenda was published earlier this year. It identified the need to learn what factors influence non-physician providers to locate and practice in rural areas. One factor was the large volume of care provided in rural areas by National Health Service Corps physicians. That care will apparently not be provided given the decline in support to the NHSC program. Most significant to us was the call for system wide changes in regulation and reimbursement. We would suggest that the changes need to include re-drafting state licensure which allows more autonomous and interprofessional collaboration and reimbursement for services provided by various health personnel, particularly if reimbursement is already provided by a physician for that service. Federal policy for Federal employees, CHAMPUS enrollees and others should be expanded to include incentives for utilization of nurse practitioners, certified nurse midwives and CRNAs. We would also suggest that reimbursement policies need to include coverage for a full range of health promotion, disease prevention and "personal support" services (counseling/educative support). These are areas where nurses excel yet, without formal regard for that work as expressed in reimbursement policy, the outcome is unmet need for those services and consequent need for more intensive and expensive treatment.

There is other evidence of quality care provided by PAs, NPs and CNMs which comes from the very large Office of Technology Assessment 1986 study. The findings concluded that within their areas of competence, NPs, PAs and CNMs provide care whose quality is equivalent to that of care provided by physicians. The OTA study also suggested that employing NPs, PAs and/or CNMs in rural physician practices which have a fee-for-service basis would be attractive to physicians who otherwise would have to work more hours in order to see enough patients in the sparsely populated rural setting to generate a desired level of income.

In terms of incentives to avert/avoid such shortages, our experiences with rural nursing indicate that providing loans/scholarships to rural residents who are entering as a first or second career choice seems to have the greatest likelihood of attracting qualified applicants who will then return to the rural setting upon completion of training. Loan forgiveness policies in return for service has been helpful in other settings, and to a lesser extent, has been demonstrated in rural settings. Arranging for student clinical experiences in rural settings and graduate student peer consultation experiences in rural settings appears to be a useful strategy which would attract and retain practitioners in rural areas. Last, a comprehensive system of continuing professional education, such as a strengthened AHEC (Area Health Education Center) system, would contribute to alleviating the sense of professional isolation from new developments which might occur among rural practitioners.

Prepared Statement of Jeffrey Human

Mr. Chairman: Thank you for the opportunity to review with you and the committee the progress of the Office of Rural Health Policy (ORHP). Let me also congratulate you on holding this important hearing and on assembling the distinguished panelists who will present this morning.

On August 3, 1987, the Secretary of the Department of Health and Human Services created an Office of Rural Health within the Health Resources and Services Administration. This office was the predecessor to the current Office of Rural Health Policy. I was named Director of the office at the time of its initiation.

Creation of the office was a response by the Secretary to expressions of concern about access to health care in rural areas, particularly the problem of the viability of small rural hospitals. It should also be noted that a number of Senators and Congressmen urged the Secretary to create such an office. Among the Senators who wrote the Secretary to support creation of the office, were 8 of the 12 members of this Subcommittee, including you, Mr. Chairman.

The office became the Office of Rural Health Policy in December 1987 as a result of passage of the Omnibus Budget Reconciliation Act of that year. That Act created a new Section 711 of the Social Security Act that mandated functions of the new office, and made it a permanent part of the Department.

DESCRIPTION OF THE OFFICE

The major responsibility of this office is to work within this Department and with other Federal agencies, States, national associations, foundations, and private sector organizations to seek solutions to health care problems in rural communities. In particular, the Office:

- Advises the Secretary on the effects that the Medicare and Medicaid programs have on access to health care in rural communities, especially with regard to the financial viability of small rural hospitals and the recruitment and retention of health professionals; and assists in the development of Department regulations and policies responsive to the resolution of these issues.
- Coordinates rural health research within the Department and administers a grant program which supports the activities of Rural Health Research Centers.
- Provides staff support to the National Advisory Committee on Rural Health.
- Articulates the views of rural constituencies within the Federal establishment.

CURRENT STATUS OF THE OFFICE

ORHP is currently staffed with seven professionals, including one detailed from the Health Care Financing Administration (HCFA). We expect a second detailed from HCFA in the near future. This office brings together staff with extensive expertise in rural health issues. Working relationships have been developed both within the Department and with a wide range of public and private sector organizations.

OFFICE ACCOMPLISHMENTS

The office has a number of completed projects and several pending:

NATIONAL ADVISORY COMMITTEE ON RURAL HEALTH

In 1988, the Secretary of HHS established a National Advisory Committee on Rural Health. Committee staffing is provided by the office. The Advisory Committee held its first meeting in September 1988. A second meeting was held in January 1989 and a third was completed on Wednesday of this week. The purpose of the committee is to advise the Secretary on the priorities and strategies that should be considered for addressing the issues and problems related to providing and financing health care services in rural areas.

This 18-member committee is chaired by former Governor Robert D. Ray of Iowa and includes members from both the public and private sectors who have a broad range of experience in rural health. I have attached a list of committee members to my testimony statement.

The Advisory Committee is organized into three work groups that address issues related to health care financing, health services delivery, and health personnel. The Health Care Financing Work Group focuses on the effects of Medicare payment policies on access to and the availability of health care services in rural areas. Its major area of concern has been the equity of Medicare payment policies for rural hospitals and physicians. The Health Services Delivery Work Group is addressing a broad range of issues including improving the availability of emergency medical services; improving access for adolescents; agricultural, occupational, and environmental health; and Medicaid benefits. The Health Personnel Work Group is addressing issues relating to the training, recruitment and retention of health personnel for rural areas. More specifically, the work group is addressing compensation, liability, student financial support, innovative training and practice models and community support programs. The Advisory Committee passed its first substantive recommendations on Wednesday.

PUBLIC REPRESENTATION

We have shared information on rural health problems through presentations, conference calls, articles, and professional papers. Our emphasis has been on the various proposals for State and community action, as well as Federal action, to solve problems. We have become knowledgeable about these programs and believe that this informal information clearinghouse role has been perhaps our most important role.

RURAL HEALTH RESEARCH

The Rural Health Research Center grant program was included as a part of the 1987 Omnibus Reconciliation Act. Within 10 months of enactment, in September 1988, we had made grants to the Universities of Washington, Arizona, North Dakota, and North Carolina, and the Marshfield Medical Foundation in Wisconsin. These centers will collect and analyze information, conduct applied research on rural health issues, and disseminate the results. The project directors of the five centers meet twice each year with us to collaborate and share information. The first monographs from a center, the University of Washington, have been issued describing the rural hospital and its role in the community.

We provided the assistance that enabled the National Rural Health Association to increase publication of its *Journal of Rural Health* from two issues per year to four issues, thus doubling the amount of research this respected Journal can publish each year.

Also in conjunction with the National Rural Health Association, we will be issuing a compendium of recent and ongoing major research projects in rural health, during the summer of 1989.

In concert with the Assistant Secretary for Planning and Evaluation, we will issue a paper describing six case studies of innovative rural health delivery programs during the summer of 1989.

MEDICARE ACTIVITIES

We have developed a strong working relationship with the Health Care Financing Administration around its legislative and regulatory proposals and its policy development and research proposals. A formal Memorandum of Agreement between us has been completed. As a part of this relationship, we have provided recommendations on numerous issues to HCFA, ranging from support for a Montana demonstration that has been approved to convert small failing rural hospitals into community health facilities with short-term holding bed capacities ("Medical Assistance Facilities") to support for higher annual payment updates for rural hospitals. The latter recommendation, incidentally, has been accepted this year.

We are assisting HCFA in the design and implementation of a program of grants to rural hospitals to make transitions in their roles in the communities they serve. That program also was authorized as a part of the 1987 Omnibus Reconciliation Act.

We will publish a *Primer on Medicare Hospital and Physician Payment* during the summer of 1989. This primer will be designed for lay readers, such as trustees of rural hospitals, to gain a basic understanding of the complex system by which hospitals and physicians are paid for the services they render to Medicare beneficiaries.

TELECOMMUNICATIONS PROJECT

We manage a departmental demonstration that is establishing an interactive satellite-based video communications system and data exchange between teaching hospitals and rural physicians and rural hospitals in Texas. Texas Tech University is the grantee.

INTERAGENCY COORDINATION

We have established ongoing collaborative efforts with the U.S. Department of Transportation on rural emergency medical systems and with the U.S. Department of Agriculture on rural economic development.

LEGISLATIVE LIAISON

We provide assistance to congressional staffs on a variety of technical issues and on local problems. I have testified at field hearings of the Senate Appropriations and Senate Aging Committees; the House Appropriations Subcommittee on

Labor, Health and Human Services; and a Texas Legislative Task Force on Rural Health and other State groups, as well as to this Subcommittee.

INFORMATION CLEARINGHOUSE

In conjunction with the National Rural Health Association, we will issue a Rural Health Resources Directory in May of 1989.

We have initiated design of an information clearinghouse. Information collection and materials development currently are scheduled for FY 1990.

In summary, Mr. Chairman, although we are a relatively new office and we are a small office, we believe we have been able to help resolve rural health problems through serving as a voice of the rural health constituency within the Executive Branch, through the programs and research we have initiated and through the technical and general assistance we have provided in rural America. We hope to continue to be of assistance in these matters.

This concludes my formal statement, Mr. Chairman. I will be happy to answer any questions you may have.

RESPONSES OF JEFFREY HUMAN TO QUESTIONS FROM SENATOR HEINZ

Question 1. When alternative delivery systems have been introduced in rural areas—to replace or augment the local hospital how have communities responded? Is there the same confidence in alternative systems or do you see patients driving further distances to get traditional, hospital-based care?

Answer. I'm not sure what you mean by alternative delivery systems. If you mean simply the substitution of outpatient clinic based care for inpatient care for an increasing number of conditions, there is little acceptance problem to speak of. There also is very little choice of treatment modes. When a given procedure starts being performed on an outpatient basis, before very long very few providers will continue to offer it on an inpatient basis. If you are also discussing the use of nurse practitioners and physician assistants, we believe they are well accepted by patient populations if they operate in a well defined system of care with significant physician involvement.

If you are using the term alternative delivery systems in the more formal academic sense, to describe a contractual system such as a health maintenance organization, a preferred provider organization or a primary care case management program, then the research so far tends to be reassuring on patient acceptance, even in rural areas. In fact, the problem may be the opposite of your concern; some researchers believe that alternative delivery systems with their minimization of hospitalization may further endanger the survival of rural hospitals.

Nowadays, when we discuss alternative delivery systems, we often also include new types of facilities. For example, the Department is currently funding a project in Montana to demonstrate the utility of a new type of facility called the Medical Assistance Facility. This down-sized hospital provides short-term acute care, emergency services, and outpatient care. Medical Assistance Facilities can be staffed by physician extenders who are under the periodic oversight of physicians.

Question 2. The bottom line in any community-based approach is the outcome for patient care. What outcome or trend data do we have to show that the quality, level, or outcome of patient care has changed after "alternative" systems to hospital- based care are introduced?

Answer. This issue is at the heart of the concerns surrounding the movement to hospital inpatient care alternatives. Based on research on the cost-effectiveness and quality of ambulatory surgery, we know that inpatient treatment is not required for many of the conditions that were treated in hospitals 10 years ago. We know that alternative delivery systems, such as health maintenance organizations, result in patient outcomes that are at least as positive, as the traditional system. We are less sure, however, of the implications for patient care of the more recent proposals for medical assistance facilities.

As I noted in the response to your last question, we are beginning to see the development of various alternative models to the hospital. The Montana Medical Assistance Facility is one example. More recently, Washington State has passed legislation that would implement a somewhat different model for an alternative care facility. California is also exploring the development of its own model. Clearly, it would be desirable to build a thorough evaluation into the development of these models to examine their effect on quality of care and patient outcomes.

Questin 3. One of my concerns is that we do not have a good research base comparing the relative outcomes of patients treated for the same conditions by different types of providers. To what extent do you support, and believe such research is valuable in ensuring high quality care? How might such research be carried out and applied?

Answer. As outlined by Secretary Sullivan in his May 24, 1989 testimony before the Committee on Ways and Means, Subcommittee on Health, this Department has had a long-standing commitment to research on patient outcomes and medical effectiveness. This office believes that more research is needed about the effects of treatment of patients with the same condition by different types of providers. We believe that the Secretary's proposal for a Medical Treatment Effectiveness Initiative in FY 1990 will provide a reasoned approach to these important studies.

Question 4. In what categories of health manpower, other than physicians, do we have or soon face serious shortfalls in rural areas? What incentives (educational, professional, and/or financial) might be offered to reverse or avoid such shortages?

Answer. Senator, we are most concerned about the nursing shortage since so many nurses are being lured to urban hospitals for higher salaries, cash bonuses, and other incentives. The American Hospital Association recently completed a survey of rural hospitals that shows that 40 percent of small rural hospitals have nursing vacancy rates of 15 percent or greater.

We also have growing shortages of nurse practitioners, physician assistants, physical therapists, and some of the allied health professionals. In general, any health professions group that is in short supply nationally is in shorter supply in rural areas.

We believe that any incentives that lead to higher compensation for health professionals in rural areas will improve their recruitment and retention. Recently, I spoke with a family physician in northern Ontario. She reported that under the Canadian health program, she earns more for serving in that remote area than she would in Ottawa, and that was a primary reason she chose to serve there. I do not think it matters much how compensation for rural providers is increased. What is important is that we succeed in offering higher compensation.

Programs such as Federal and State-sponsored area health education centers, which bring continuing education and consultation programs from university health science centers to the isolated practitioner, help make rural areas more attractive practice alternatives by improving the professional environment.

Prepared Statement of John Mengenhausen

Chairman and members of the Subcommittee: My name is John Mengenhausen. I am the Executive Director of East River Health Care, Inc. in Howard, South Dakota and am here today representing the National Association of Community Health Centers and the more than 600 Community and Migrant Health Centers across the country. Thank you for this opportunity to come before the Senate Finance Subcommittee on Medicare and Long-Term Care and speak to the financing and reimbursement issues facing Community and Migrant Health Centers.

BACKGROUND ON COMMUNITY AND MIGRANT HEALTH CENTERS

- Community Health Centers (CHCs) provide prevention-oriented, comprehensive case-managed primary health care services to medically disadvantaged populations in their communities. In 1987, there were 532 CHC grantees (330 which are located in rural communities) serving 5.2 million persons.
- Migrant Health Centers (MHCs) deliver care-coordinated primary health services to an estimated 500,000 migrant and seasonal farmworkers and their families annually.
- Services for special populations at C/MHCs are targeted at particularly high-risk groups within the overall medically underserved population. These include: perinatal services to pregnant women and their infants, the homeless, substance abusers, the mentally ill, HIV-infected persons, migrant farmworkers and the elderly.

Taken together, these programs form the core of the federally supported effort to make basic health care available to medically underserved communities. In recent years an increasing proportion of their patients have come from the most vulnerable population groups. The health centers actively responded by re-focusing their services to meet these special needs.

Even as they are meeting these special needs, health centers have shown themselves to be effective and efficient providers of care:

- They are responsive to their communities. Centers receive a high degree of acceptance and utilization in communities they serve, and have helped to close the health care "gap" that historically separated poor and non-poor Americans.
- They promote the use of preventive health services and reduce reliance on hospital emergency rooms.
- They have significantly improved the health of communities they serve. Major reductions in infant mortality—as much as 40 percent—have been achieved in areas served by health centers, due to the access they provide to high quality maternity and infant care services.
- They provide high quality care, including clinical management of patients, completeness of care, and follow-up.
- They dramatically reduce hospital use and costs for patients. Health centers' impact on hospitalization costs means that they have more than paid for themselves.

CHALLENGES FACING COMMUNITY HEALTH PROGRAMS

Various problems are increasingly hindering health centers from fulfilling their mission to provide care to underserved vulnerable populations. One challenge facing health centers is the ever-increasing number of people seeking services. New waiting lists are averaging between IS and 28 percent of the current patient enrollment. Health centers report a 300 percent increase in the number of pregnant women seeking care, thus' placing significant pressure on their limited obstetric services. In rural areas, closures of hospitals and physicians' offices have left entire communities in great demand of health care services. Between 1986 and 1 987, rural centers had a 7.8 percent increase in the number of patients; of these, 83 percent were uninsured. Furthermore, increasing numbers of homeless persons and those with AIDS are using health centers.

While demand for services has increased significantly, grant funding for centers has decreased over time. Centers are operating at the same level of funding in 1989 as there were in 1987. In fact, 1989 funding is 25 percent lower than 1981 levels after adjustment for inflation.

Federally funded community health centers in rural areas are losing ground financially. In a one-year period, community health centers' operating expenses increased 14 percent, subsidies for uninsured patients increased 11 percent, and bad debts were up 25 percent. During this time, federal funding for the centers increased only 11 percent—not nearly enough to cover the financial shortfall faced by many of the nation's community health centers.

A recent study conducted by the National Association of Community Health Centers and the National Rural Health Association,[1] shows a net loss in the nations' community health center revenues of $28,711,000 even after federal grants increased 11 percent ($19,827,000) for the years 1986 and 1987. Much of this decrease in revenues can be attributed to the declining rural economy. As more rural residents are under-insured or uninsured, centers are burdened by an increase in charity care and reduced cash flow. This economic threat to centers is even greater because in many areas it is coupled with an increased demand for community health center services.

To make a bad situation worse, health centers suffer from inadequate reimbursement for services to Medicare and Medicaid patients. Many private physicians have responded to payment freezes and cuts by reducing or eliminating their participation in Medicaid, or by refusing to accept Medicare payment levels. Meanwhile, publicly funded and private community-based providers who are obligated to furnish health care to the poor have been struggling to provide care to Medicare and Medicaid beneficiaries without being reimbursed for the reasonable cost of that care. In 1988, state Medicaid reimbursement levels on average were adequate to cover only about 70 percent of the cost of routine care furnished by health centers. As a result, public and private grant funds are increasingly being used to cover the shortfall in Medicare/Medicaid reimbursement rather than supporting the care for the uninsured as originally intended. Because these clinics carry a disproportionate share of Medicare and Medicaid patients and have virtually no cost shifting capacity, the burden is even greater.

Finally, the Rural Health Clinics Act falls well short of its promise to increase availability of primary care in rural areas and assure providers in these areas adequate reimbursement of costs of care to Medicare and Medicaid beneficiaries. When the Congress passed P.L. 95-210 in 1978, it envisioned more than 2,000 rural health clinics (RHCs) by 1990. Yet, today only 438 RHCs are certified. Less than 100 of the 330 rural community health centers are participating in the RHC program. Seventeen mostly rural states have no RHCs. Over the years, 388 former RHCs have withdrawn from the program; most have complained of bureaucratic problems and inadequate payment levels.

The HHS Office of Rural Health Policy estimates that the program is hampered by a lack of knowledge about the program, restrictive state practice acts for physicians' assistants and nurse practitioners, administrative barriers, and shortages of nurse practitioners and physicians' assistants. It was only last year that the Congress raised the RHC cap from $32.10 to $46 given that HCFA had allowed the cap to stagnate since 1983 at the $32.10 level. Now that the reimbursement cap reflects more accurately costs and inflation, it is necessary to focus on enhancing participation in the program.

RURAL HEALTH CLINICS ACT

Senator Rockefeller should be applauded for his leadership in developing amendments to the Rural Health Clinics Act designed to enhance participation in this program and, therefore, increase access to primary care in rural areas. The National Association of Community Health Centers supports the following amendments to the Rural Health Clinic Act:

1. *Simplified Certification for Health Centers Funded under Sections 329/330/340 of the Public Health Service Act.* The Rural Health Clinic (RHC) certification provisions in Section 1861 should be amended to specify as eligible, those clinics that are located in areas designated as rural, that employ qualifying mid-level practitioners, and that receive funding under Section 329, 330 or 340 of the Public Health Service Act. This change would streamline certification procedures for those rural clinics that meet the standards/requirements for funding under Sections 329, 330 or 340.
2. *Clarification of Eligible Geographic Areas.* It is recommended that shortage area definitions be clarified to assure the appropriate reference to Medically Underserved Areas (MUA) in the eligibility criteria and the inclusion of Medically Underserved Populations (MUP) and governor generated designations in the eligibility criteria. This change would eliminate confusion about the shortage area definition;

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[1] *Community Health Centers and the Rural Economy: The Struggle for Survival*, December, 1988.

allow the governor of any state, upon approval of HHS, to designate a medically underserved area or population; and provide for greater flexibility for rural health clinics to participate in the program.

3. *Modify Existing Standards for RHC Certification to Allow Flexibility in the Employment of Mid-Level Practitioners.* The Congress should provide flexibility in the present regulatory requirements to ensure that a mid-level practitioner who is onsite 50 percent of the clinic's operating hours is sufficient to meet qualification standards. It is further recommended that the HHS Secretary by given authority to grant waivers if the RHC demonstrates reasonable efforts to recruit a mid-level practitioner. These changes would provide flexibility for clinics seeking or attempting to maintain RHC certification who are experiencing difficulty recruiting mid-level practitioners who are in short supply.

4. *Clarification of the Inclusion of Nurse Midwifery Services.* Section 1861 should also be amended to clarify that midwives can be recognized as a type of mid-level practitioner that will meet RHC certification requirements. This change would mean that the services of nurse midwives are not only reimburseable under RHC status but that their employment should be recognized as meeting the mid-level practitioner requirements for purposes of certification; and permit rural sites which presently use nurse midwives to be eligible for RHC status, thus improving access to obstetrical and perinatal care for rural residents.

5. *Public Information on the RHC Program.* It is recommended that the Office of Rural Health Policy be assigned the responsibility of developing and distributing RHC program brochures and other written informational material. This requirement would assure that program information is circulated amongst state and local officials and providers and therefore, enhance participation in the program.

FEDERALLY FUNDED HEALTH CENTER PROGRAM

Community and Migrant Health Centers find themselves in the position of grant dollars, that were provided to assure access for uninsured patients, are often used to subsidize Medicare and Medicaid because these programs do not pay the cost of care for these beneficiaries. Because health centers are on the frontlines providing care to the medically underserved, they experience a disproportionate share of uninsured and underinsured patient loads. Recognition of these unique providers in Medicare and Medicaid reimbursement is necessary to maintain access to care for the underserved.

Senator Chafee also should be applauded for his leadership role in developing Medicare/Medicaid amendments designed to assure reimbursement to community and migrant health centers on an all-inclusive rate basis similar to the Rural Health Clinics Act. Medicare currently pays many federally funded community health centers (FFHC) on an all-inclusive rate basis. However, this payment system is based upon a regulatory provision (42 CFR Sec. 405.312f) established in 1976 under a special statutory exception (42 USC Sec. I 395y(a)(3)). Payment authority for FFHC needs to be clarified and strengthened.

The National Association of Community Health Centers supports the following amendments to the Medicare and Medicaid program:

1. *Strengthen the Statutory Basis in Medicare of the Federally Funded Health Centers-(FFHC) Program.* It is recommended that the Federally Funded Health Center (FFHC) program be codified to: (1) include services covered under Part B of Medicare; (2) extend eligibility for FFHC agreements to Section 340 grantees of the Public Health Service Act (Health Care for the Homeless) and clinics that can meet qualification standards for Section 329, 330 or 340 grantees of the Public Health Service Act as determined by the Secretary of HHS; and (3) permit eligible entities to be reimbursed based upon the current FFHC methodology (found in regulations) of 80 percent of reasonable cost.

These changes would codify the current regulatory programs for FFHC in the Medicare law; add federally-funded Health Care for the Homeless grantees as entities eligible for FFHC agreements; and clarify that clinics that meet qualifying conditions through a process to be established by the Secretary of HHS but do not receive PHS Section 329/330/340 funds, are treated as eligible entities for the purpose of participation in Medicare as a FFHC.

2. *Extend Applicability of the FFHC Program to Medicaid Reimbursement.* It is recommended (consistent with current Rural Health Clinic provisions) that the FFHC program be codified and made applicable to Medicaid to: (I) recognize community health clinic services to the extent covered under the state plan; and (2) provide reasonable cost reimbursement as an option to FFHC using the same cost finding principles used for Section 329, 330 and 340 PHS grants. These changes would man-

date use of community health clinic services under Medicaid; allow an eligible entity to elect reimbursement as a community health clinic; and use 329/330/340 cost principles (which include recognition of the cost of services furnished by mid-level practitioners) for Medicaid covered services.

3. *Clarify Medicare Coverage Even When Charges are Discounted as Required by law.* It is recommended that language be added to the Medicare statute in order to coordinate Medicare requirements with Public Health Service Act rules regarding the provision of sliding scale discounts for low-income persons by health centers receiving grants under Sections 329, 330 and 340 of the PHS Act. These changes would allow a health center to be reimbursed for its reasonable charges, without offsetting deductions or disapproval by Medicare of the health centers waiver of deductibles and coinsurance amounts for low-income patients under the PHS required sliding scale discounts provisions; provide a safe harbor from criminal or civil violations under Medicare's anti-kickback laws where an FFHC gave a full or partial waiver of Medicare copayments and deductibles (based on each centers sliding income scale rules) to a low income person who qualifies for service subsidized under the PHS Act; and assure that Medicare recipients are able to meet Medicare copay and deductible requirements if they are low-income patients of health centers.

All in all, reforming Medicare and Medicaid payments systems for community-based providers will assure increase access to health care for Medicaid and Medicare beneficiaries as well as the uninsured because these government insurance programs will cover the reasonable cost of services to their beneficiaries and allow precious grant dollars to be targeted for care to the uninsured. Enactment of these payment reforms would allow federally-supported Community and Migrant Health Centers to *serve 426,000 more low-income patients in 1990.* Protecting these "disproportionate share" health centers and rural health clinics under Medicare Part B payments cuts will maintain access to primary care for the underserved.

Finally, the National Association of Community Health Centers understands that Senator Pryor will soon introduce the Rural Primary Care Incentive Act of 1989 that will address the need to attract and retain needed health care personnel to underserved rural areas. This legislation would provide for the use of tax incentives and the elimination of current tax disincentives to attract physicians to isolated rural areas and thus increase access to primary health care. Be assured, Senator Pryor, that the National Association of Community Health Centers' staff will continue to work with you for quick passage of this legislation and that Community and Migrant Health Centers will greatly benefit from its enactment.

PREPARED STATEMENT OF RALPH TABOR

Senator Rockefeller and members of the Subcommittee, my name is Ralph Tabor and I am the Director of Legislation for the National Association of Counties. I am very pleased to be here today to discuss the Medicare program and its relation to health care in the rural areas of our country. We are especially pleased to offer the view of county government on this issue and appreciate you including us at this hearing.

Our presence here reflects the commitment of county elected officials to assuring that the residents of their communities have access to quality health care services. We are deeply concerned about health care needs in rural areas and identifying the best mechanisms to finance, administer and deliver health care services to the residents in those areas.

County governments play an important role in the delivery of health care services as evidenced by the following facts:

> Of the nation's 3,106 counties, 2,400 are considered rural and 389 meet the six person per square mile definition of frontier areas. 2,257 counties have populations of less than 50,000 persons.
>
> 1986 data from the Census Bureau indicates that counties spent $14.7 billion on health care, $7.2 of that on hospital services.
>
> County governments are responsible for a large portion of the health and human service needs of their residents; almost all counties administer and pay part of the contribute to the financing of the federal/state/county network of social services, health and welfare programs.
>
> In 19 states, counties bear the sole responsibility for health care to the indigent, and share it in 11 more. Even in those 14 states where the state itself is legally responsible for indigent health care, counties often end up bearing a healthy share of that responsibility.

Because of their responsibilities in this regard, and severely constrained fiscal resources at the local level, counties are often heavily dependent on federal programs such as Medicare to assure the fiscal stability of their health care system.

We have several concerns for the influence and impact of the Medicare program on the services of health professionals in rural areas. We know that an earlier hearing focused on the problems associated with rural hospitals and we would like to add our voice to those in support of the elimination of the current urban/rural differential payment rates in the Medicare program. Some rural county hospitals have as much as two-thirds of their patients paid for by Medicare. Since we did not have an opportunity to testify before today, we would like to request to be allowed to submit additional comments on S. 306 and other pending legislation on rural health care issues.

In regard to professional services, we find just as urgent a need to address the various inequitable differentials that exist for services in rural areas. In this regard, the federal government can do several things: adjust reimbursement and support professional training, and it can promote the restructure of service systems, either through caveat or irresistible incentives for integration and collaboration at the local level.

SUPPORT FOR HEALTH PROMOTION AND DISEASE PREVENTION SERVICES

County health departments, with traditional public health programs of prevention and health promotion, childhood immunization, and maternal and child services, have a keen appreciation for the value of prevention and early intervention. We strongly support incentives for the provision of primary care services and feel that reimbursement for such services should be increased. The work on relative value scales for physicians services reinforces this approach. We would add that increased reimbursement for preventive and primary care services should be broadly available to other qualified professionals, especially nurse clinicians.

We would like special attention paid to the availability of home health services in rural areas. In Minnesota for example, we understand that county governments are paying increasing amounts for home care services because patients discharged from hospitals require more intensive attention than current reimbursement rates cover. In rural areas, the lack of professional follow-up can mean the difference between successful outcomes and relapse into disabling conditions. In particular, this means support for possible adjustments to reimbursement rates to reflect more intensive services, and training and incentives for therapists to provide post-hospital care in rural areas.

INCENTIVES FOR TRAINING AND PRACTICE IN RURAL AREAS

We strongly support adopting special incentives and reimbursement adjustments to entice health professionals to practice in rural areas. The elimination of differential urban and rural rates should apply to professional as well as hospital services.

We feel strongly that the discussion of health professionals in rural areas must move beyond attention to the supply of physicians. In a county in northeastern Washington, the only available physician left town and the local hospital closed. However, the health care needs of the community were still well met by the services of a nurse practitioner. It is time that we focused on how health professionals can be better utilized in rural areas.

In general, we would like to see greater support for the use of non-physician services for care where warranted. We hear a great deal about the value of mid-level practitioners in rural areas, especially nurse practitioners and physician assistants, and yet concrete proposals seem to focus most on recruiting more physicians into rural areas. These incentives should be broadly available. Nurse clinician services have been directly incorporated in the development of rural health clinics, established under Medicare in 1978, which take advantage of nursing skills with minimum supervision from physicians. Although I000 such clinics were anticipated by this time, just over 400 exist. We would appreciate assistance in seeing local health departments take advantage of this option so that more rural areas can benefit.

Many county health departments in rural areas have a single nurse clinician to meet local needs. We would like to see programs that would assist these facilities, enable them to become rural health clinics, or link them to primary care centers. This would promote access to needed services and integrated services.

We support expanding the number of teaching hospitals to conduct demonstrations to develop field clinical experience in rural areas for physicians and other health professionals. We also support promoting linkages such as the nursing demonstration program proposed in S. 306. We are currently aware of the criticism levied at the physician education support being provided by Medicare, however, and would hate to see a program so critical as nursing education placed in a similar precarious position. We would rather urge the Subcommittee to request your colleagues on other appropriate committees to increase support directly for health professions education in general, with special incentives for post-training practice in rural areas.

LINKAGES WITH COUNTY GOVERNMENTS AND LOCAL PUBLIC HEALTH DEPARTMENTS

We would like to see support for broader reform and the development of non-traditional arrangements for service delivery. In particular, we support linkages among providers at the local level, such as between primary care clinics and local public health departments. Where such collaboration exists, costly duplication of services can be avoided, but it currently occurs only where leadership exists, not from program design. Candid opinion from local health professionals is that such linkages would be enhanced by program requirements from the federal government.

All health care providers in a community must work together and have a clear understanding and agreement about the responsibilities they each have for service provision. Given the scarce resources and special needs, it is critical that integrated planning and collaboration occur. Counties need federal programs to recognize this need and to build in assurances of communication between federally funded programs and local elected officials. Where county health departments and community health centers work together, they bring the best of both traditional public health and primary care services to local residents. We would like to see more attention to these efforts and encouragement for their greater use.

We support expanded funding for the Community and Migrant Health Centers Programs with special attention to the ease with which such facilities can be established in rural areas. The only place in Montana that has a Community Health Center is Billings, and we understand that this is because at least partly because the requirements to establish CHCs are simply unrealistic in a rural area.

We return to the problem of equating rural health care needs with physician supply. State licensure laws for medical facilities can be changed and many states are exploring licensing for alternative facilities to meet needs in rural areas. However, the Medicare requirement for physician staffing in hospitals hampers many facilities from adopting alternative arrangements. We would like to see more demonstrations of alternative delivery sites, mobile clinics, and the medical access facilities that are now in place in Montana. Rural hospitals often find Medicare requirements difficult to meet and could be allowed greater flexibility in their organization in order to provide a more limited scope of services.

We would like to see special attention paid to the repercussions for staffing and integration of services being explored in the Rural Health Care Transition grants program, just now getting underway. One of the criteria for transition grants is to specify anticipated coordination with local or regional health groups and local government groups. This should be a model for other programs authorized in the future. Local governments are accountable to the residents of their communities; linkages between local governments and federally supported programs ensure that programs truly meet local needs.

We are aware of proposals to increase the $50,000 limit for the transition grants program and to extend it for two more years. We support this, and would also like to see systematic attention paid to adopting some of the proven program elements as permanent features in the Medicare/Medicaid program. We spend a great deal of federal money on demonstration programs and yet continue to allow certain services and system arrangements only under special waivers. We would like to see these experiences incorporated in the basic structure of the Medicare and Medicaid programs.

In closing, county concerns in these areas are in many ways little different from other provider groups. As public entities, however, without the advantage of private sector financing mechanisms, county institutions and facilities rely on budgets limited by local tax bases, and are politically accountable to the residents they serve for both budgets and programs. We would like to see more attention to the development of alternatives in administering and staffing rural health care services that would merit federal reimbursement and enhance the viability of these efforts.

PREPARED STATEMENT OF JAN TOWERS

This document is submitted in behalf of the American Academy of Nurse Practitioners to address the needs for rural citizens to access quality health care with particular reference to the recruitment and use of nurse practitioners In rural health care settings in this country.

It has become clear that the current health needs of our rural populations are profound. Not only do these groups of people have higher concentrations of children under the age of 18 and adults over the age of 65. They have higher levels of poverty, higher levels of maternal and infant mortality, and higher rates of chronic disease than people in urban areas of the country.(1)

The status of these needs becomes more acute when one considers not just the current, but the future health needs of the population. It is reported that by the year 2000, the percentage of the populations most in need of health care die. the poor and the elderly, will have increased substantially. It Is estimated that the elderly population alone will comprise thirteen percent of the total population.(2) Current estimates identify the poverty rates among the elderly at twelve per cent, those age 85 and over having double the rate (21%) as those age 65 to 74.(3) Another seventeen percent have been estimated to be among the near poor.(4) The rates among minority populations are reported to be the highest. In addition, it has been estimated that twenty percent of the children in this country are poor.(5)

Nurses are the major health care providers for these populations in both acute and ambulatory care settings.

According to preliminary findings from the National Survey conducted by the American Academy of Nurse practitioners, (6) Nurse Practitioners practice in rural areas in all fifty states. The majority are Family Nurse Practitioners, followed by Women's Health Nurse Practitioners and Pediatric Nurse Practitioners. In very rural communities (population <1000) they are found predominantly in free standing primary care centers and public health clinics. In semi-rural areas and small towns (population 1000–49,000) they are practicing predominantly in free standing primary care centers, public health clinics and in private practices, usually with a physician. Seventy three percent of the Nurse Practitioners functioning in rural areas have elderly people among their patients; eighty three percent see children under the age of 12.

Nurse practitioners are needed to provide primary care to mothers, infants and children as well as to the elderly everywhere, and particularly in areas unable to attract and retain physicians. The quality and cost effectiveness of their care has been documented in numerous studies (7,8,9,10, 11,12,13,14,15). Yet with this documented track record for quality and cost effective care, only 13% of the Nurse Practitioners in very rural and 10% in semi-rural areas report that they have nursing home privileges, and only 29% in both groups report having hospital privileges. In addition, of the 48% of those practicing in very rural areas and 35% in semi-rural areas who provide services that are reimbursable through third party payment less than 5%, (4.9% in very rural and 3.8% in semi-rural areas) obtain direct reimbursement for their services (16).

Nurses don't need to be forced into these roles, not do they need large financial incentives to keep them there. They do need to have opportunities to be prepared to practice in these areas, the ability to practice in a manner fitting their advanced education and an equal opportunity to receive direct reimbursement for their services, however.

Given the above data, the barriers to retaining and increasing the utilization of nurse practitioners in rural areas becomes obvious. The quality of care and cost effectiveness of Nurse Practitioners have been demonstrated over and over again, yet their inability to obtain direct third party reimbursement (in the case of the elderly: Medicare reimbursement), their inability to practice in extended care facilities and to provide services in rural hospitals tie the hands of these highly competent health care providers. Such barriers make functioning in rural settings frustrating and consequently potentially undesirable to would be practitioners.

Accessing quality cost effective health care is an important issue to nurse practitioners. The Academy therefore endorses the initiatives in the rural health legislation currently being introduced by Mr. Rockefeller. The Academy also endorses the development of medical assistance facilities in rural areas unable to support the presence of a full service hospital.

Additional legislative solutions which could contribute to the alleviation of problems of access and contribute to the recruitment and retention of nurse practitioners in rural health care include:

1. Publicizing the availability of rural health clinic classification and reimbursement mechanisms to nurse practitioners and facilities interested in utilizing nurse practitioners.

In our interaction with nurse practitioners throughout the country, we are acutely aware of the fact that little is known among nurse practitioners about the methods for establishing rural health clinics, for applying for classification as a rural health clinic or the funding that is available through this channel.

2. Provision of Medicare reimbursement for medical services provided by Nurse Practitioners in extended and primary care facilities other than rural health clinics.

Under the current law, elderly patients (other than those being seen in federally funded rural health clinics) who wish to see a Nurse Practitioner, are forced instead to see a physician In order to have their care reimbursed by Medicare. Ex. At a health center in North Dakota it has been reported that Medicare recipients arriving at a clinic manned part of the week by nurse practitioners and two days a week by a physician, must be turned a.way and sent to a neighboring town where there is a physician if they come for care on the day the physician is not in attendance. (Not a pleasant undertaking in North Dakota in midwinter).

Nurse Practitioners rate high in consumer satisfaction; they have been demonstrated in over 400 studies to provide quality, cost effective care (17). The provision of Medicare reimbursement to nurse practitioners for medical services rendered would not add to the expense, but rather reduce the cost of providing health care to the elderly in rural areas. Record (18) and Denton (19) in their investigations, calculate savings of $300,000,000 to $1,000,000,000 per year if Nurse Practitioners were used to provide the services they are qualified to provide.

3. Recruitment of nurses from rural areas into Nurse Practitioner programs via scholarships and educational stipends in order to facilitate their return to those areas.

4. Ensuring that the 1989 levels of funding Nurse Practitioner education authorized in the Nursing Shortage Reduction and Education Extension Act of 1988 are appropriated so that more nurse practitioners may receive stipends and assistance to meet educational costs they incur.

Questions have been raised regarding the ability to keep nurses with advanced preparation In rural areas, particularly those with Masters degrees and higher. According to the Academy survey, 32% of the respondents from the very rural areas had Masters degrees and 34% from the semi-rural areas had Masters or Doctorates. (20) Even in the presence of the problems discussed above, Masters prepared Nurse Practitioners do stay and practice in rural areas. It seems logical that with better working and reimbursement conditions, even more would be interested in functioning in this environment.

5. Provision of GME funds to agencies and institutions in rural areas for preparing nurse practitioners to work with this underserved population.

Studies indicate that students who have an opportunity to have learning experiences in rural settings often find practicing in such settings rewarding enough to return after graduation. Enabling rural agencies to provide practice sites for nurse practitioner students through this funding would greatly facilitate rural communities in their recruitment and retention of nurse practitioners.

6. Providing opportunities for increased access to continuing education through scholarships and increased funding for services to rural health settings.

The ability to network with other professionals and remain current in their specialty, assists practitioners In maintaining an attitude of satisfaction, regardless of practice site, but particularly among those in more isolated geographic areas. Facilitating such services would enhance the retainability of the Rural Nurse Practitioner.

7. Inclusion of nurse practitioners in demonstration projects involving the use of telecommunications in patient care and continuing education in rural areas. Several initiatives are being discussed for physicians that should be broadened to include other health care providers involved in rural health care.

Nurses and nurse practitioners are particularly well prepared to care for the underserved and the indigent, for mothers and children and the elderly. Large segments of our nursing curriculums are devoted to helping students to understand and implement care in settings and among patients and clients with limited resources, financial and otherwise. The majority of nurse practitioners work for some, if not all their professional lives among the poor and underserved. In the previously mentioned survey of the American Academy of Nurse Practitioners, an average of 65% of the patients seen by Family, Pediatric and women's Health Nurse Practitioners had annual incomes of less than $15,000 per year. Eighty-one percent of people seen by gerontologic nurse practitioners were reported to be in that Income bracket. (21)

In addition, nurse practitioners are well suited to care for mothers and children, and the elderly due to their dual preparation in nursing and medical arenas. They are prepared to assist these populations by managing their chronic and acute medical conditions as well as assist in the attaining and maintenance of a higher quality of life by guiding and supporting their health promoting activities both physical and emotional.

In Summary, Nurse Practitioners are viable and valuable health care providers in rural communities. With additional enabling legislation such as that described above, the ability to recruit and retain those providers will be greatly enhanced. The Academy wishes to thank the Finance Committee for its concern for the health care of the people in rural America, for we too are concerned about the ability of these people to access quality cost effective health care both now and in the future. We would like to help and appreciate the opportunities you can provide to allow us to do that.

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RESPONSES BY DR. JAN TOWERS TO QUESTIONS FROM SENATOR HEINZ

Question 1. One of my concerns is that we do not have any good research base comparing the relative outcomes of patients treated for the same conditions by different types of providers. To what extent do you support and believe such research is valuable in ensuring high quality care? How might such research be carried out and applied?

Answer. The literature is replete with studies demonstrating the quality of care provided by "different types of providers" for the same conditions. In all cases regarding nurse practitioners, the quality of care, measured in satisfactory outcomes, provided by nurse practitioners was found to be equal to that of physicians providing the same kind of care. I would suggest that you review the text of the 1986 Office of Technology Assessment for further documentation on this issue. I have also enclosed a list of additional resources that may be useful in examining this topic further.

Certainly, we are supportive of all research that examines the effect of medical and health regimens of care on patient outcomes, and feel that such studies should always be conducted in order to insure the highest quality of care with the best outcomes for the patient. Numerous outcome studies have been conducted In the areas of patient compliance and various treatment regimens. Such studies are and should continue to be conducted in an ongoing manner by all health care professionals in all settings.

Question 2. Expanding direct reimbursement to multiple providers raises several, potentially problematic issues such as the potential for (1) discontinuity in patient care, (2) unbundling (and higher costs) of care, (3) opportunity for induced (and unnecessary) referrals, and (4) exclusion of the primary care physician. How might we protect against these risks in expanding Medicare's direct payment policy?

Answer. Medicare reimbursement to nurse practitioners would enhance continuity of care rather than create discontinuity. Currently, while nurse practitioners are very capable and willing to provide primary care to patients in their settings, they must arrange for physician contact with each visit, necessary or not, in order to allow Medicare to pay for their visits. This practice not only provides discontinuity for the patient and provider, but pulls the physician away from dealing with the complicated medical issues that come to the setting requiring his/her attention. Robyn and Hadley report on a study of the comparison of two ambulatory care sites utilizing nurse practitioners to two matched control sites not utilizing nurse practitioners. Continuity of care provided by nurse practitioners was a factor in reducing hospital admissions and duration of stay among patients in the clinics utilizing nurse practitioners. Those clinics had reduced rates compared to the control clinics not utilizing nurse practitioners.

Unbundling should not be an issue with nurse practitioners, since the services for which reimbursement is being sought are not reimbursable to employees in settings such as hospitals where unbundling is identified as a problem for nurse anesthetists, for example.

The concern for unnecessary referrals implies that nurse practitioners don't know what they're doing. Why would there be any more unnecessary referrals from one competent group of professionals than another? If anything, it would allow the physician to be used more appropriately and cost effectively to treat and manage those medical problems requiring the skill and expertise commensurate with his/her preparation.

Primary care physicians would not be excluded if Medicare reimbursement were provided for nurse practitioner services. Rather, if nurse practitioners were able to function as they have been prepared, physicians could be used more effectively deal with the more complicated medical problems for which he/she has been prepared, and with which they prefer to work. Nurse practitioners work collaboratively with physicians in the provision of medical care to patients; this is not a problem for currently practicing nurse practitioners or physicians with whom they collaborate in local offices and clinics.

The State Nurse Practice Acts which regulate the activities of nurse practitioners throughout the country already protect against whichever the above risks may be considered to be a threat. Conversely, Medicare reimbursement to nurse practitioners would insure a higher quality of care, more continuity, better use of professional time at cost effective rates. Elderly patients appreciate and desire skilled, quality care in the manner in which it is provided by nurse practitioners.

Question 3. In what categories of health manpower, other than physicians, do we have or soon face serious shortfalls in rural areas? What incentives (education, professional and/or financial) might be offered to reverse or avoid such shortages?

Answer. As was stated in my testimony, nurse practitioners are needed and desired to provide primary care to residents of all ages in rural areas. Methods for providing incentives include, provision of stipends and scholarships for residents In rural areas to complete the necessary educational programs in order to return home to practice, provision of rural practicums to students in nurse practitioner graduate programs, increased continuing education opportunities through networking and telecommunications to the practitioner in the rural area and the provision of Medicare reimbursement to nurse practitioners are all incentives that would assist in the recruitment and retention of nurse practitioners in rural areas.

COMMUNICATIONS

AMERICAN MEDICAL ASSOCIATION

June 9, 1989

Hon. JAY ROCKEFELLER, *Chairman,*
Subcommittee on Medicare and Long-Term Care,
Committee on Finance,
U.S. Senate

Dear Chairman Rockefeller: The American Medical Association requests that the enclosed statement be included in the record of the Hearing on Rural Health Care that the Subcommittee on Medicare and Long-Term Care held on May 19, 1989. The AMA has long supported efforts to ensure that individuals in rural areas have adequate access to health care. As the Subcommittee is well aware, there are a variety of difficulties that inhibit access to health care in rural areas.

Despite the variety and severity of problems, the AMA believes that adequate access to health care in rural areas can be achieved. However, the approaches to improving access must be as diverse as the problems themselves are. A major goal of the AMA is that all individuals have some form of health care coverage—through state risk pools, a restructured Medicaid program, an adequately financed Medicare program, employer-provided health insurance, and a system to finance long-term care. In addition, adequate support must be given to programs that encourage health care practitioners to practice in rural areas, and health care professions education programs must continue to find innovative ways to be involved in rural health.

Our statement also provides the AMA's views on establishing equitable Medicare reimbursement for physicians' services. Due to the historical basis of Medicare reimbursement (1989 payments are based on 1971 charges) physicians in many areas, rural areas in particular, are not treated fairly. These problems are exacerbated in rural areas given their higher proportion of Medicare beneficiaries. To assure equitable reimbursement, the AMA supports the establishment of an indemnity payment schedule for physicians' services, with indemnity amounts based on a relative value scale that reflects physicians' resource costs for providing services. Since the establishment of such a system is some time off, the AMA will, this month, be considering endorsement of an interim approach that would raise the floor of reimbursement payments to ensure that rural physicians are adequately reimbursed.

The AMA commends the Subcommittee for its interest in rural health and offers its assistance in any way possible to help you identify and determine approaches to address the variety of difficulties facing rural health care.

Sincerely,

JAMES H. SAMMONS, MD

Enclosure.

STATEMENT OF THE AMERICAN MEDICAL ASSOCIATION

The American Medical Association appreciates the opportunity to share with the Subcommittee on Medicare and Long-Term Care some of the Association's ideas about the health care and health care financing needs of rural Americans. As members of the Subcommittee are well aware, access to health care in rural areas can be inhibited for a number of different reasons. In some instances, the problem is one of financial access. In others, the primary cause may be a lack of health manpower, facilities, transportation, or a lack of coordination between available resources. In still others, inadequate provider reimbursement levels may inhibit access to needed care.

The AMA believes that ways exist to improve access to care in rural areas. However, the approaches to improvement must be as diverse as the problems themselves are, and must be tailored to meet local needs and conditions.

RESTRUCTURING MEDICAID

Unrealistically low levels of reimbursement, widely varying benefit levels and stringent eligibility requirements under Medicaid are a major area of concern for the AMA. These problems inhibit access to health care in many rural areas, as well as across the country. The time has come for a basic restructuring of the Medicaid program so that uniform adequate benefits are provided across all states, at adequate payment levels, to all persons with incomes below 100% of the poverty level (state-adjusted). The AMA has developed a proposal for such reform.

We fully recognize that an expansion in Medicaid of this magnitude will result in a major increase in the number of eligibles and in program costs. However, society already bears a large part of these costs in other ways, including lost productivity and ultimately higher costs of care that results from postponing needed medical attention, and the burden of uncompensated care. The question is not *whether*, but rather *how* such costs can be met in a way that best preserves the health of the needy, while apportioning the load equitably over all sectors of the economy.

Accordingly, we intend to actively seek and support changes in the Medicaid program of this magnitude, and invite the Subcommittee to join us in supporting that effort.

ESTABLISHING STATE RISK POOLS

A major need exists to increase the ability of many rural Americans to afford needed health services. Rural areas were particularly hard hit by the economic decline in the early 1980s. A number of the industries on which the rural economy is largely dependent are still struggling to recover from that economic downturn.

As one method to increase the financial base for support of rural health services, the AMA has urged the establishment of state health insurance risk pools as a means of assuring that adequate health insurance coverage is available, at a reasonable cost, to persons with incomes above the poverty level. The pools should provide a specified level of adequate benefits, and premiums should be set at neither less than 110% nor more than 125% of the average premium for comparable group coverage by insurers in the state. States should provide publicly funded vouchers on a sliding scale to help those persons with incomes between 100% and 150% of the poverty level pay the premium for pool coverage. About five million people would qualify for such voucher assistance. Persons with incomes between 150% and 200% of the poverty level also should be eligible to purchase pool coverage, but at their own expense.

It is likely that the costs of risk pool coverage would not be met totally through enrollee premiums. In that event, risk pool costs in excess of premium income should be spread as widely as possible. The AMA believes strongly that states should be allowed to require all health care underwriting entities in the state, including commercial carriers, non-profit medical service plans, health maintenance organizations, and self-insured plans, should be required to participate in the risk pool. By having all such entities participate, the pool would be assured a financial base sufficient to support the program and to achieve a fair sharing of the risks. Unfortunately, states are prohibited by federal law, the Employee Retirement Income Security Act (ERISA), from requiring that self-funded employee benefit plans participate in state risk pools. This prohibition creates strong barriers to effective operation of state risk pools since self-insured plans write over half of the employee group health insurance business. While fifteen states currently have risk pools, these existing pools are more limited than the AMA proposal.

In order to achieve broad participation in state risk pools, the AMA has developed draft federal legislation that would amend ERISA to allow states to regulate self-insured plans in the same manner that other health insurance plans are regulated. Self-insured plans would thus have to participate in state risk pools. The AMA has also developed draft federal legislation that would make available the deductibility of health insurance premiums only to employers that either participate in the risk pool directly, if self-insured, or that purchase group health insurance coverage from an entity that participates in the risk pool.

PROVIDING HEALTH INSURANCE TO EMPLOYEES

Of the approximately 37 million U.S. citizens who are currently uninsured, about 26 million are workers or their dependents. As the third piece in an overall approach to protecting the uninsured, the AMA's Board of Trustees has endorsed the concept of a phased-in requirement that all employers provide health insurance coverage for their full-time employees, limited initially to larger employers, with coverage expanding over several years and with a program of diminishing tax credits or other incentives to avoid adverse effects on employers. Recommendations for endorsing this policy will be presented to our House of Delegates for approval this month.

FINANCING LONG-TERM CARE

The AMA has recommended a number of steps to improve the financing of long-term care (LTC) expenses, which can be catastrophic for many individuals. We support extension of present Medicaid LTC benefits to all individuals below the poverty level and the establishment of tax incentives to encourage the purchase of private LTC insurance coverage, including a program which allows LTC patients to protect an amount of assets from Medicaid spend-down requirements equal to the amount of benefits paid for their care by private LTC policies they purchase, and tax deductions to encourage family care giving.

ENSURING ADEQUATE MANPOWER

In addition to improving the financial accessibility of care, we believe that a number of steps also can be taken to help improve the supply and distribution of manpower in rural areas as well. The AMA supports continuation of the National Health Service Corps as a method for extending medical care to rural shortage areas. To help effectuate the work of the Corps, the AMA has, since 1973, sponsored Project USA, a program which recruits short-term physician replacements for Corps and Indian Health Service physicians who need time off for continuing education or other purposes.

In addition, the AMA supports forgiveness of educational loans and other financial inducements for health care providers who choose to practice in shortage areas. Over the longer term, we believe that medical and other health professional schools should give increased emphasis to attracting more students who are motivated to care for underserved populations, and should provide more opportunities for exposure to rural practice as a part of the educational experience. To that end, the AMA sponsors research on the effect of educational programs to enhance students' choice of rural practices. Currently, over 100 medical schools indicate that they have such programs.

The AMA also provides physicians with the demographic and market data to help them make more informed practice location decisions, and have developed information on ways in which medical staffs of rural hospitals can obtain high-quality, cost-effective continuing medical education programs, so that professional stimulation and attractiveness in rural practice locales can be maintained.

IMPROVING PROS

The AMA has been concerned that some standards and practices of statewide Peer Review Organizations (PRO) may result in a disproportionate number of rural physicians being unfairly sanctioned. We have worked with Congress and the PRO program to modify such practices. One result of this effort is that PROs are now required to use physician reviewers who practice in settings similar to those of the physicians who are being reviewed. With the passage of the Hall Amendments (P.L. 100-203), we have also been able to achieve appropriate due process protections for rural physicians who are being monitored or reviewed by a PRO.

ESTABLISHING EQUITABLE MEDICARE REIMBURSEMENT

Inadequate levels of Medicare payment to physicians and hospitals are a major impediment to access in rural areas—particularly given the higher proportion of Medicare beneficiaries in rural areas.

With regard to physician payment, the Physician Payment Review Commission, in its report to Congress last year, found substantial variation in Medicare prevailing charge levels among the 240 Medicare charge localities, even after adjusting for differences in the costs of practice. Variation that cannot be explained by cost of practice differences can jeopardize access to care and threaten beneficiary financial protections in areas where prevailing charges are low, and can impact with special severity on rural areas which are already hard-pressed to retain an adequate supply of physicians.

Inadequate levels of physician reimbursement in many rural areas stem from the constraining effects of the Medicare Economic Index applied to 1971 charges, coupled with subsequent limits on the charges of non-participating physicians, which have not allowed physicians' reimbursement and fees to rise with relative changes in the costs of providing care. In all areas where the costs of practice have risen more rapidly, the gap between Medicare payment for services and the costs of providing those services has progressively widened.

As the most equitable approach to establishing physician payment levels, the AMA believes that Medicare's current method of physician payment should be replaced with an indemnity payment schedule, with indemnity amounts based on a relative value scale (RVS) which reflects resource costs. Since 1986, the AMA has been working as a subcontractor to Harvard University in a HCFA-financed study to develop such a resource-based RVS.

The study was undertaken in response to a Congressional mandate to the Secretary of HHS to develop such an RVS by July 1989, and the final report of the first phase of the Harvard study was released this past September. The AMA and other groups have identified a number of refinements and modifications needed in the Harvard results before it could serve as the basis for an indemnity fee schedule under Medicare, and AMA will continue as subcontractor to Harvard in this second phase of the study.

The AMA believes that the current Harvard study and data—when sufficiently expanded, corrected, and refined—would provide an acceptable basis for a Medicare indemnity payment system. We also believe that the indemnity payments under such a system should only reflect valid and demonstrable differences in practice costs, including professional liability insurance premiums. Finally, we believe that a method of further adjusting payment levels to remedy demonstrated access problems in specific areas needs to be developed.

ESTABLISHING AN INTERIM APPROACH TO FAIR MEDICARE REIMBURSEMENT

While an RVS-based indemnity payment system represents the best ultimate approach to physician payment reform, the Association recognizes that the initial implementation of such a system may be some time away. Accordingly, the AMA has studied possible interim approaches to redressing inequities in rural physician payment under the present system, including proposals to limit the range of geographic variation in prevailing charge levels while, at the same time, avoiding major movement of charges in a direction opposite to that which would occur under a resource-based RVS.

Within the next three weeks, the AMA's house of Delegates will be considering a policy position that the Association seek the legislative changes necessary to establish a floor on Medicare prevailing charges for all services at 80% of the national average prevailing charge for those services. This approach would permit Medicare allowed charges to increase immediately in areas where they are constrained by prevailing charges lower than 80% of the national average. We will inform the Committee of the results of these deliberations.

Simulations developed by the AMA's Center for Health Policy Research indicate that such a change would increase net federal Part B outlays by a little less than 4 percent, or $482 million. (Net federal outlays are defined as federal budget expenditures net of the revenue offset produced by maintaining Part B premiums at 25% of Part B expenditures.)

Congress has already acknowledged the need to address access problems through increasing the prevailing charge. The 1987 Omnibus Budget Reconciliation Act established a prevailing charge floor for primary care services at 50% of the average prevailing charge levels for participating physicians in all Medicare charge localities. Given that problems of access to other than primary care services also exist, the AMA believes I that a floor should be established for all services, not only for primary care services.

PROVIDING ADEQUATE MEDICARE REIMBURSEMENT TO HOSPITALS

With respect to hospitals, the AMA is concerned that inadequate Medicare payments under the Medicare Prospective Pricing System (PPS) could jeopardize the ability of rural hospitals to provide quality patient care to Medicare and non-Medicare patients alike. Over the past few years, the Association has supported specific legislative provisions to improve the economic outlook for many rural hospitals, dealing with such areas as a revised Gross Salary Wage Index, disproportionate share adjustments, more liberal criteria for hospitals to qualify as rural referral centers,additional payments to sole community hospitals, and separate outlier pools for rural hospitals.

We strongly supported the 1988 recommendation of the Prospective Payment Assessment Commission (ProPAC), that the PPS update factor for N89 be set at 3.8

percent for urban hospitals and 4.6 percent for rural hospitals. This recommended increase was greater than those actually allowed by Congress in the Omnibus Budget Reconciliation Act of 1987.

The Department of Health and Human Services and Congress should follow the recommendations of ProPAC and assure adequate hospital reimbursement to guarantee that Medicare beneficiaries continue to receive high quality care.

CONCLUSION

The AMA has a strong and ongoing commitment to improving access to needed health care for individuals in rural areas. We will be happy to assist the Subcommittee in any further way as you continue to consider solutions to the variety of problems that too often make such access difficult.

Statement of Communicating for Agriculture

Chairman Rockefeller, members of the Committee, I want to express our appreciation to you for hearing the views of our organization, Communicating for Agriculture, which represents a wide range of consumers of rural health care.

Communicating for Agriculture is a national, non-profit, non-partisan organization made up of farmers, ranchers, small town independent business people, their employees and families in more than 40 states. We survey and represent our members on a wide range of issues, including rural development, rural education and agricultural policy and development. One division of our organization—Communicating For Seniors—serves the interest of rural senior citizens.

Rural health care has been a priority issue for Communicating for Agriculture since it was founded some 15 years ago, and it has taken on even greater importance over the past two years because *the cost, the quality, the availability, and the very future of health care in rural America is rapidly becoming a crisis.* It is appropriate that this Subcommittee examine ways that Medicare can be reformed to ease this rural health care crisis, because Medicare's problems have a significant cause-and-effect relationship with each of those symptoms . . . symptoms which indicate that the rural health care system is in need of emergency treatment.

One-third of the nation's elderly live in rural areas, compared to only one-quarter of the overall population. Consequently, rural health care providers serve a disproportionately larger share of the over 65, Medicare recipient population. When Medicare pays rural providers from 20 to 40 percent less than urban providers for the same procedures, it is inevitable that those policies will eventually cause extreme financial difficulties for Medicare dependent providers. Many rural hospitals now have a patient base that is made up of more than 50 percent Medicare business, a level which analysts say threatens financial failure for those facilities.

It is important to recognize that fixing Medicare's urban/rural reimbursement rates won't solve the entire rural health care crisis, nor will it alone solve all of the financial challenges faced by rural hospitals. But it is just as important to recognize that none of those problems will be cured until those discriminatory reimbursement polices are ended and rural providers and rural consumers are given equal treatment. There are two overall recommendations that we urge Congress to address regarding Medicare reforms:

1. Congress should pass the Equity for Rural Hospitals Act with a stepped-up phase in of one national hospital reimbursement rate for Medicare. And the guidelines whereby hospitals with a large Medicare patient-ratio would temporarily be reimbursed on an operating cost basis should be lowered from 70 percent patient-ratio to at least 50 percent.
2. Congress should recognize that the rural health care community is actively working to adapt to the challenges it faces, and the federal government should provide stronger support to assist an evolution to a system that is better suited to meet the future needs of the local communities.

More than 200 rural hospitals have gone under since 1980, and the Senate Select Committee on Aging recently cited a projection that nearly 600 rural hospitals are threatened with closure over the next 10 years.

In Communicating for Agriculture's view, this is not simply an issue just for the rural medical community and senior citizens. This is a fundamental quality of life issue for families and businesses in thousands of rural communities whose health care delivery systems are on the verge of decaying below what may already be second class status, or becoming non-existent. Rural hospitals are a major employer in their communities, and when they close their doors there is a loss of valuable jobs that have been staffed by skilled professionals. Moreover, rural development efforts, which are now being pursued in many of those same rural communities, take a severe setback. What company wants to locate a new facility, and what new business wants to set up shop, in a community with inadequate health care? It doesn't happen.

As already has been documented, there is a growing problem in recruiting qualified health care personnel—physicians, nurses and therapists in particular—to practice in rural communities. Unfair reimbursement rates again are pegged as a critical factor. The message to health care professionals now is very clear—if you want to receive a fair wage, practice at quality facilities and have a bright future, rural areas are not the place to go.

This is not to say every rural hospital can and should be saved. There are some facilities that lack the equipment, expertise and population to continue to operate as a full fledged hospital. But, by and large, these facilities understand and are now actively seeking to adapt to meet the needs of their changing population base. Yet, there are many other facilities, also seeking to adapt to the needs of their community, that could remain open if they received fair and equal federal payment for their Medicare business.

On a positive side, it is heartening to note how many rural hospitals and providers are pulling together and searching for a way to keep financially afloat while offering better care. Hospitals throughout rural America are actively diversifying their services. Many are changing into long-term care facilities to meet the needs of their aging population. Others are networking with other rural hospitals and urban hospitals. Some are merging to reduce overhead and be able to offer and support specialized services.

I am told nearly 700 rural hospitals applied for grants under the recently implemented Rural Hospital Transition Grant Program. Less than half are likely to be approved. This clearly demonstrates that rural hospitals are willing, even anxious to change for the better—even when it means changing from a hospital into a different form of health care facility.

It also clearly demonstrates, however, that inadequate funds have been appropriated to meet the demand and need for this worthwhile program. *We are pleased to see that the Equity for Rural Hospital's Act. Senate Bill 306 would raise funding for the program to $25 million. and we urge you to move forward to see that the program is funded and equipped to do the job it has been set up to do.* This is one key way for the federal government to become a stronger partner in supporting and influencing a positive evolution of the rural health care system.

In addition there should be an expansion, beyond a few pilot projects, to allow for flexibility in Medicare reimbursement:

- To cover care performed by supervised, qualified nurse practitioners in remote areas where no full-time physician is located.
- To support special emergency care and temporary acute care facilities where a hospital cannot be supported, such as Montana's Medical Assistance Facility program.
- To support other new and emerging rural health care systems that may lack the traditional size qualifications for Medicare payments, but can demonstrate they serve a base of Medicare-eligible people in need of care and will maintain quality health care delivery standards.

And finally, we urge that you make certain rural interests are adequately represented on Medicare's Prospective Payment Assessment Commission. We've been told there is a shortage of members of the commission who have personal experience dealing with the unique operations of rural hospitals.

In summary, inequitable rural Medicare reimbursement rates are a clear cut case of unfair discrimination and pose a major threat to the viability of the health care systems serving rural Americans. Rural American's pay the same basic premium rates for Medicare and there is no reason they should receive 20 to 40 percent less in reimbursement compared to consumers of urban providers. We urge Congress to approve the Equity for Rural Hospitals Act without delay, and enlarge the federal government's role as a partner in encouraging an evolution to an improved rural health care system that is tailored to the needs of local communities.

Rural consumers understand that changes are necessary and that they may have to drive further to receive specialized care. But they expect the basic services, especially acute care and emergency care, to be available nearby, and that all health care services are available to them within reasonable distances and that they will be second to none in quality.

Thank you.

STATEMENT OF THE HOSPITAL ASSOCIATION OF NEW YORK STATE (HANYS)

On behalf of over 70 rural facilities in New York State—over 50 of which qualify for federal "rural" designation—I wish to thank you for the opportunity to present our views. These hospitals range from 400-bed medical centers serving remote multi-county regions to 20-bed facilities located in tiny mountain hamlets. Despite their individual dissimilarities, they have in common certain problems related to their status as rural institutions:

- Local labor pools are dwindling, leading to difficulty in recruiting hospital staff.
- Depressed economic conditions contribute to poor health among the remaining population, a growing proportion of which is elderly.
- Inadequate reimbursement and (in New York State particularly) unrealistic regulatory mandates further exacerbate existing financial difficulties.

Despite widespread recognition of the vital role played by our rural hospitals, and the threat posed by their precarious financial conditions, the plight of rural hospitals is worsening. The May 15 issue of *Medicine and Health* reported that nationwide more than 40 rural hospitals closed in 1988 alone; 206 rural hospitals have closed since 1980. Texas, California, and New York have been particularly hard hit. In New York State, five rural facilities have closed their doors since 1986, three of them within the last year.

One of the major factors accelerating these closures is the Medicare Prospective Payment system (PPS), implemented nationwide in 1984 and in New York State in 1986. Hospitals in New York State have mirrored the nationwide experience of rapidly declining Medicare margins, and future projections point to increasing difficulties. If the proposed federal Medicare cuts are implemented, the situation for many rural facilities will be desperate if not fatal.

HANYS is heartened that several important pieces of legislation have recently been introduced which seek to address the plight of rural hospitals. Some bills, such as S. 306, introduced by senators Bentsen and Dole, address urban/rural rate differentials, a source of great frustration for rural hospitals since the advent of PPS. The Association is also aware that legal challenges have been mounted over the issue of inadequate Medicare rural rates, and that rulings are pending.

HANYS is gratified that steps are being taken to restore cost-based reimbursement for those small rural institutions whose reasonable costs are not being reimbursed under Medicare. Currently, five bills (S. 10 and S. 227, H.R. 168, H.R. 1168, and H.R. 1270) address this issue. The bill introduced by senator Moynihan (S. 227) would, for example, offer rural hospitals with fewer than 150 beds an option to be exempted. HANYS believes this approach would provide smaller rural institutions with a reimbursement option more accurately reflecting individual circumstances.

RECOMMENDATIONS

The Hospital Association of New York State offers the following recommendations:

1. Exempt rural hospitals with fewer than 150 beds from the Prospective Payment System through the development of an "opt-out" option reflecting "actual" (rather than "average") reasonable costs.

PPS reimbursement is predicated on the average cost of treating different types of patients. However, rural hospitals are smaller than their urban counterparts and one or two exceptionally costly cases can quickly skew a facility's average costs. At the same time, the impact of small decreases in admissions greatly affect their revenues; small rural hospitals do not have the flexibility to adjust their staffing or expenses to reflect sudden changes in occupancy. Because it seems unlikely that a single national reimbursement system can be calibrated to reflect the special needs of all rural facilities, we would prefer an alternative system which offers an option to rural hospitals.

2. Allow a hospital to appeal the use of its area wage factor adjustment if it can demonstrate that the data on which the factor is based do not accurately reflect the relative hospital wage level in the hospital's geographic area.

The use of an inappropriate wage factor adjustment results in reduced reimbursement and can severely impact a hospital's ability to pay competitive wages to attract and retain qualified staff. The right to appeal on a technical basis would provide a needed mechanism to resolve this type of inequity.

3. Extend the Medicare Disproportionate Share payment criteria and qualifying standards that are currently applicable to urban hospitals with 100 or more beds to include rural hospitals with 100 or more beds.

Currently, only rural hospitals with 500 or more beds have payment criteria similar to large urban hospitals. Moreover, rural hospitals with fewer than 500 beds must demonstrate that 45% of their caseload are low income patients as opposed to 15% for large urbans. Rural hospitals having less than 500 beds are limited to a 4% payment adjustment, whereas there is no limit for large urban hospitals. This higher standard penalizes those rural hospitals which serve large numbers of low-income patients having many of the same characteristics their urban counterparts. HANYS believes that all rural hospitals with more than 100 beds should receive the same disproportionate share adjustment for treating low-income patients as afforded to large urban hospitals.

4. Expand demonstration projects which offer clinical experience in rural health care settings for physicians in residency programs.

The availability of sophisticated services (e.g., cardiology and oncology) increases demand for specialized personnel. Rural hospitals which cannot meet that demand are losing their patient base due to out-migration. Even if money were available to hire individual specialists, severe physician recruitment problems remain and supplying suitable back-up coverage and peer support is made even more difficult by this situation. In attempting to meet patient needs locally and maintain sufficient service volume, rural hospitals must recruit physicians in a variety of areas, including the primary care specialties of general surgery, obstetrics, internal medicine and pediatrics. Highly attractive program and financial incentives are needed to persuade doctors to set up their practices in underserved rural areas.

5. Make increased grant funding available to assist rural hospitals, both directly (staff support in the areas of planning, recruitment/retention, etc.) and indirectly (through research and development of innovative service models).

Because of cost constraints, few rural hospitals have the resources available to hire the specialized personnel who could help them address their financial problems and create innovative programs which "do more with less." Yet many facilities are barely able to maintain existing programs, let alone develop new or expanded ones. Specialists in the areas of strategic planning, marketing, and financial consulting could help rural hospital administrators confronting an increasingly complex regulatory, financial and operating environment.

Because problems of limited financial and human resources fall especially hard on rural hospitals, HANYS believes that deliberate action to redress these problems is needed immediately to reinvigorate the system and improve both access and quality of care. We thank you for your thoughtful consideration of our proposals as we think they represent important steps in this direction.

STATEMENT OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

The National Association of Social Workers (NASW) is pleased to offer its testimony on the crucial issue of rural health care delivery, especially mental health care. It is abundantly clear that the health care needs of the rural population are not being adequately met; the main problem is lack of access.

NASW's particular concern lies with the lack of mental health care for rural citizens. Current law does not go far enough in allowing Medicare beneficiaries the freedom to select a provider from among the range of regulated and qualified mental health care professionals. Ironically, while restricting beneficiaries from utilizing many mental health care professionals, Medicare goes overboard for physician-providers in the other direction. It does not even require that' mental health services be performed by a trained mental health professional—any physician will do.

In this respect, the Medicare program is out of step with today's mental health delivery system, which is universally recognized to consist of four core disciplines: psychiatry, psychology, clinical social work, and psychiatric nursing. Consequently, the 25% of the general population and ⅓ of the elderly population who live in rural areas are often denied access to care simply because of the restrictive policies in the Medicare financing structure.

There are several compelling reasons why it is critical to extend Medicare coverage to services provided by clinical social workers and all other qualified mental health professionals. First, freedom of choice helps to alleviate the problem of insufficient access to mental health care, particularly among underserved populations. Second, expansion of the pool of qualified mental health providers encourages healthy competition, enhancing cost-containment. And finally, increased utilization of mental health treatment has been shown to result in decreased utilization of costly medical and hospital services.

The ability of a consumer to select from a range of qualified mental health care providers for reimbursable care can determine access to mental health care—particularly in rural areas. A recent study, commissioned by NASW, illustrates this point. The pilot study of the relative distribution of social workers, psychologists and psychiatrists in six states with large rural areas—Illinois, Oklahoma, Michigan, Texas, Florida and West Virginia—found that:

1. Social workers are the only licensed mental health providers in approximately ¼ of the counties in 5 of the 6 states studied; and
2. The counties in which social workers were the sole providers were rural and generally poorer than neighboring counties, with average per capita incomes ranging between $6,686 to $10,347—25% below the states' average.

Inadequate access to mental health services and to trained mental health professionals led the President's Commission on Mental Health in 1978 to recommend that Medicare and other publicly financed mental health service programs should provide direct reimbursement to all independent qualified mental health professionals who meet the requisite standards of education, experience and professional licensure/certification. This included the list mentioned before: psychiatrists, psychologists, clinical social workers and psychiatric nurses.

Some opponents of freedom of choice have argued that expanding the available provider base will cause a significant increase in utilization, and additional cost. However, even if utilization were to increase with the inclusion of clinical social workers in the provider pool, overall plan costs would not necessarily increase proportionately. On the contrary, the evidence strongly suggests savings. For example, the aforementioned President's Commission on Mental Health concluded that increased utilization of mental health services leads to decreased utilization of doctors, hospitals and surgery. "Research from health maintenance organizations, from industrial programs, and from regular health insurance plans suggests that providing outpatient mental health services can reduce overall health services utilization and overall health costs." (The President's Commission on Mental Health, *Report to the President,* "Report of the Task Panel on Cost and Financing," Vol. II, p. 1128.).

The Commission also determined that as much as 60% of physician visits are from sufferers of emotional distress rather than diagnosable physical illness. (The President's Commission on Mental Health, "Report of the Task Panel on Mental Health of the Elderly," Vol. III, p.1128).

A recent visit to a rural health clinic in West Virginia by NASW representatives confirmed this view. The clientele of the clinic are primarily Medicare beneficiaries. The clinic used to employ the services of a social worker but, due to funding cutbacks, are no longer able to maintain the position. Patients with mental problems are referred to the nearest community mental health center. However, due in part to the lingering stigma attached to mental illness and the logistical problems of getting to the center, the vast majority of patients never go to their appointments. Therefore, the staff—a pediatrician, an internist, and a nurse practioner—serve by default as therapists. The pediatrician, for example, described a current child abuse case she had where another child in the family is also suspected of being abused. She expressed feeling "helpless" and suggested that a social worker would know how to work more effectively with the family. In fact, the availability of a clinical social worker in a clinic would allow medical providers time to do those duties for which they are trained—primary medical care. As it is, the patient load is approximately 4 patients an hour, 20 a day for each of the staff. The hiring of a clinical social worker, or other qualified mental health care provider, would not only free up time for more patients, but would also remove the stigma of going to a "mental health center" for the patient.

The lack of trained mental health providers in rural health clinics was reiterated time and time again in discussions with other clinic administrators. Child and spouse abuse, depression, alcohol and drug abuse and teenage pregnancy are other mental health problems that continue to go untreated. These are all problems which would benefit from social work expertise.

Federally funded health insurance programs such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) and the Federal Employees Health Benefits Program (FEHBP) have already recognized the importance of utilizing services of clinical social workers and other qualified non-physician providers. A 1986 study conducted by the Office of Personnel Management examined the effects of providing direct reimbursement to clinical social workers and other non-physician providers under FEHBP. 0PM concluded that there was no basis to anticipate adverse impact on cost or quality of care from mandating coverage of qualified non-physician providers, including clinical social workers.

The CHAMPUS program drew a similar conclusion. In 1980, Congress directed CHAMPUS to conduct a two-year demonstration project of clinical social workers as autonomous providers of services in order to assess the impact on cost and utilization. Following the project in 1982, Congress authorized continuation of independent provider status based on the finding that "no quality of care problems have arisen . . . and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach." (Senate Appropriations Committee Report No. 97-580, 97th Cong., 2d Sess., p.32).

The issue of access to quality mental health care for rural citizens is a top priority for NASW. NASW strongly recommends that the Subcommittee broaden the scope of Medicare coverage to include the services of clinical social workers in rural health clinics.

We appreciate the opportunity to express our views to the Subcommittee and look forward to working together to improve the delivery of mental health care in rural areas.

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